

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

FOR
STATE
REGISTRAR

1 DECEASED NAME (TYPE OR PRINT) James James I Amerault		2a DATE OF DEATH MONTH DAY YEAR 9 8 83		2b HOUR 4:57 PM	
3 SEX Male	4 RACE White	5 DATE OF BIRTH MONTH DAY YEAR Oct. 18, 1899	6 AGE (IN YEARS LAST BIRTHDAY) 83 YRS	7 IF UNDER 1 YEAR MONTHS DAYS HOURS MIN	
BIRTHPLACE (STATE OR FOREIGN COUNTRY) Nova Scotia	7b CITIZEN OF WHAT COUNTRY? U.S.A.	8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	9 BALTIMORE CITY OR COUNTY OF DEATH Howard County MD.		
10 CITY OR TOWN OF DEATH Columbia	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Howard County General Hospital	12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Retired	12b KIND OF BUSINESS OR INDUSTRY B & O R.R.		
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE Maryland		13b. COUNTY Anne Arundel	13c. CITY OR TOWN Hanover	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>	13e. STREET ADDRESS 7545 Race Road
14 FATHER'S NAME FIRST MIDDLE LAST late Thomas Amerault		15 MOTHER'S MAIDEN NAME FIRST MIDDLE LAST late Laura Camerau			
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) Yes		16b SOCIAL SECURITY NO W.W. 1 705 10 1777		17 INFORMANT ADDRESS Thomas E Amerault 3034 Ellicott City 21043 Hickorymede Dr.	
18 CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c) PART I: DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardiopulmonary Arrest 4960 CONDITIONS, if any, which gave rise to immediate cause (a), stating the underlying cause last: (b) Congestive Heart Failure. (c) Chronic Obstructive Pulmonary Disease					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH Months Years
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1:					
19a DATE OF OPERATION		19b CONDITION FOR WHICH OPERATION WAS PERFORMED		20a AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
21d INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f LOCATION STREET CITY OR TOWN COUNTY STATE	
22a I certify that (I) (this hospital) attended the deceased from Aug 29 , 19 83 , to Sept. 8 , 19 83 , that (I) (we) last saw the deceased alive on Sept 7 , 19 83 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b SIGNATURE James J. Lennie		DEGREE W.		22c DATE SIGNED 9-8-83	
22d PHYSICIAN'S NAME (TYPE OR PRINT) Deary E. Levine		22e ADDRESS 10802 Hickory Ridge Rd, Columbia, Md 21044			
23a BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b DATE SEpt. 10'83		23c NAME OF CEMETERY OR CREMATORY Meadowridge	
23d LOCATION CITY OR TOWN Columbia		COUNTY Howard		STATE Maryland	
24 FUNERAL DIRECTOR NAME Harry H Witzke 4112 Columbia RD		ADDRESS Ellicott City		25a DATE REC'D. BY REGISTRAR SEP 9 1983	
		25b REGISTRAR'S SIGNATURE John J. Camish			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon copies. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner will be notified at

Howard Marshall

Howard Marshall

Howard Marshall

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. FOR STATE REGISTRAR		2a. DATE OF DEATH		2b. HOUR	
1. DECEASED NAME (TYPE OR PRINT)		MONTH DAY YEAR		MONTHS DAYS HOURS MIN.	
FIRST MIDDLE LAST		9/15/83		1:15 AM	
3. SEX		4. RACE		5. DATE OF BIRTH	
female		white		MONTH DAY YEAR	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
PA.		Howard		9. BALTIMORE CITY OR COUNTY OF DEATH	
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)	
Columbia		Howard Co. Gen. Hosp.		HOUSEWIFE	
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)		13b. COUNTY		13c. CITY OR TOWN	
MD		Howard		Columbia	
14. FATHER'S NAME		15. MOTHER'S MAIDEN NAME		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES NO OR UNKNOWN)	
FIRST MIDDLE LAST		FIRST MIDDLE LAST		NO	
LESTER J. LOST		BLOWEYN EVANS		16b. SOCIAL SECURITY NO.	
17. INFORMANT		ADDRESS		16c. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
MARK ASH II		10063 WINDSTREAM DR COLUMBIA MD 21044		21044	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)					
PART 1. DEATH WAS CAUSED BY:					
4039 IMMEDIATE CAUSE (a) Pulmonary Edema					
DUE TO, OR AS A CONSEQUENCE OF (b) chronic renal failure					
DUE TO, OR AS A CONSEQUENCE OF (c) Hypertension					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a)					
none					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY?	
—		—		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
		P.M. 19		—	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from 1975, 1983, to 9-14, 1983, that (I) (last) saw the deceased alive on 9-14, 1983, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did not) view the body after death.					
22b. SIGNATURE		DEGREE		22c. DATE SIGNED	
Levan Koch		MD		9-15-83	
22d. PHYSICIAN'S NAME (TYPE OR PRINT)		22e. ADDRESS		22f. MEDICAL <input checked="" type="checkbox"/> STAFF <input checked="" type="checkbox"/> PHYSICIAN DIRECTOR PHYSICIAN	
LEVAN KUCH MD		HOWARD COUNTY GENERAL HOSPITAL			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY	
CREMATION		9/16/83		WESTVIEW MEMORIAL PARK	
24. FUNERAL DIRECTOR NAME		25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE	
JOSEPH LEE CANGY FUNERAL DIRECTOR		12590 INDIAN HILL DR ADDRESS		SEP 16 1983	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH				REG. NO.			
1. DECEASED NAME (TYPE OR PRINT) NORMAN C. BAREHAM				2a. DATE OF DEATH MONTH DAY YEAR Sept. 19, 1983			
3. SEX Male		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR April 20, 1934		6. AGE (IN YEARS LAST BIRTHDAY) 49 YRS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Howard County MD.	
10. CITY OR TOWN OF DEATH Ellicott City		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 4709 Parkvale Road		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Engineer		12b. KIND OF BUSINESS OR INDUSTRY Westinghouse	
13a. STATE Maryland		13b. COUNTY Howard		13c. CITY OR TOWN Ellicott City		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST late Elmer D. Bareham				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Anna May Ensor			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) = yes		16b. SOCIAL SECURITY NO. 213 32 4300		17. INFORMANT ADDRESS Mrs Elveras Bareham 4709 Parkvale Rd 21043			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute Pulmonary Edema, respiratory Failure 1519 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last: DUE TO, OR AS A CONSEQUENCE OF (b) Cocaine and liver metastases DUE TO, OR AS A CONSEQUENCE OF (c) Basal Carcinoma							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 6 hrs 8 mo. 14 mo.
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: no							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR 8/19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)			
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from 8/19 to 9/19 19 83 , and that in my (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did not) view the body after death.							
22b. SIGNATURE Wm C Waterfield				DEGREE MD		22c. DATE SIGNED 9/20/83	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Wm C Waterfield				22e. ADDRESS St Agnes Hospital 900 Cath Ave Balt 21229			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE Sept 23, 1983		23c. NAME OF CEMETERY OR CREMATORY Crestlawn		23d. LOCATION CITY OR TOWN COUNTY STATE Howard, Maryland	
24. FUNERAL DIRECTOR NAME Harry N Witzke 4112 Columbia Rd Ellicott City				25a. DATE REC'D. BY REGISTRAR SEP 26 1983		25b. REGISTRAR'S SIGNATURE John J. Conner	

BP

Barry H Witzke 4112 Columbia Hillcrest City
 Sept 13, 1983
 Crossland

Howard, Maryland

212 32 4500 Mrs Riveras Barham 4709 Parkway Rd 21043

= yes

Korean

Jane Elmer D. Barham

Anna May

Enoch

Maryland

Howard

Hillcrest City

4709 Parkway Road

Hillcrest City

4709 Parkway Road

Barham

Westinghouse

Maryland

U.S.A.

Howard County

Male

White

April 20, 1983

49

Sept. 13, 1983

NORMAN C. BARHAM

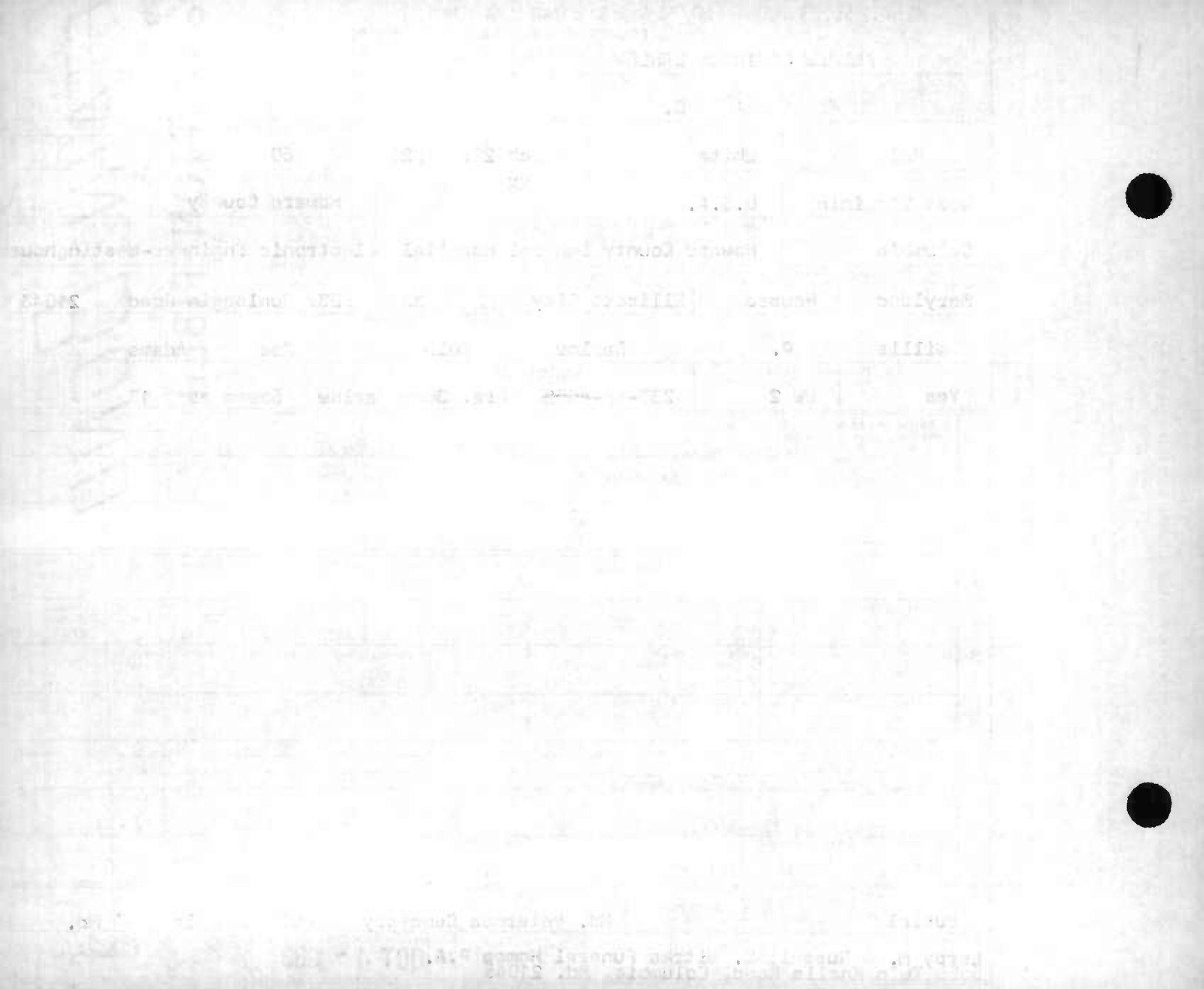
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MEDICAL CERTIFICATION

1. FOR STATE REGISTRAR ANDREW DAVISON BARLOW CERTIFICATE OF DEATH										REG. NO.	
1 DECEASED NAME (TYPE OR PRINT) ANDREW D. BARLOW						2a. DATE OF DEATH MONTH 9 DAY 30 YEAR 83		2b. HOUR 1:55 P.M.			
3 SEX Male		4 RACE White		5. DATE OF BIRTH MONTH March DAY 28 YEAR 1923		6 AGE (IN YEARS LAST BIRTHDAY) 60 YRS.		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN. 			
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY) West Virginia		7b CITIZEN OF WHAT COUNTRY? U.S.A.		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH Howard County MD.					
10 CITY OR TOWN OF DEATH Columbia		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Howard County General Hospital				12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Electronic Engineer		12b KIND OF BUSINESS OR INDUSTRY Westinghouse			
13a. STATE Maryland				13b. COUNTY Howard		13c. CITY OR TOWN Ellicott City		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
14 FATHER'S NAME FIRST Willis MIDDLE P. LAST Barlow				15 MOTHER'S MAIDEN NAME FIRST Eula MIDDLE Mae LAST Adams							
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) Yes		16b SOCIAL SECURITY NO. WW 2		17 INFORMANT Mrs. Joan Barlow		ADDRESS Same as # 13					
18 CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: 4254 IMMEDIATE CAUSE (a) CARDIO RESPIRATORY ARREST. DUE TO, OR AS A CONSEQUENCE OF (b) CONGESTIVE CARDIOMYOPATHY Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO, OR AS A CONSEQUENCE OF (c) APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 10 days											
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a): 											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)							
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE							
22a. I certify that (I) (this hospital) attended the deceased from 9/20 , 19 83 , to 9/30 , 19 83 , that (I) (we) last saw the deceased alive on 9/30 , 19 83 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE Krishna P. Kumar				DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>				22c. DATE SIGNED 9:30.83			
22d. PHYSICIAN'S NAME (TYPE OR PRINT) KRISHNA P. KUMAR				22e. ADDRESS 11065 Little Patuxent Parkway Columbia Md 21046							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 10/26/83		23c. NAME OF CEMETERY OR CREMATORY Md. Veterans Cemetery		23d. LOCATION CITY OR TOWN Dwings Mills COUNTY Md. STATE Md.					
24. FUNERAL DIRECTOR Leroy M. & Russell C. Witzke				ADDRESS Funeral Homes P.A.		25a. DATE REC'D. BY REGISTRAR OCT 4 - 1983		SIGNATURE John J. Calver			
5555 Twin Knolls Road, Columbia, Md. 21045											

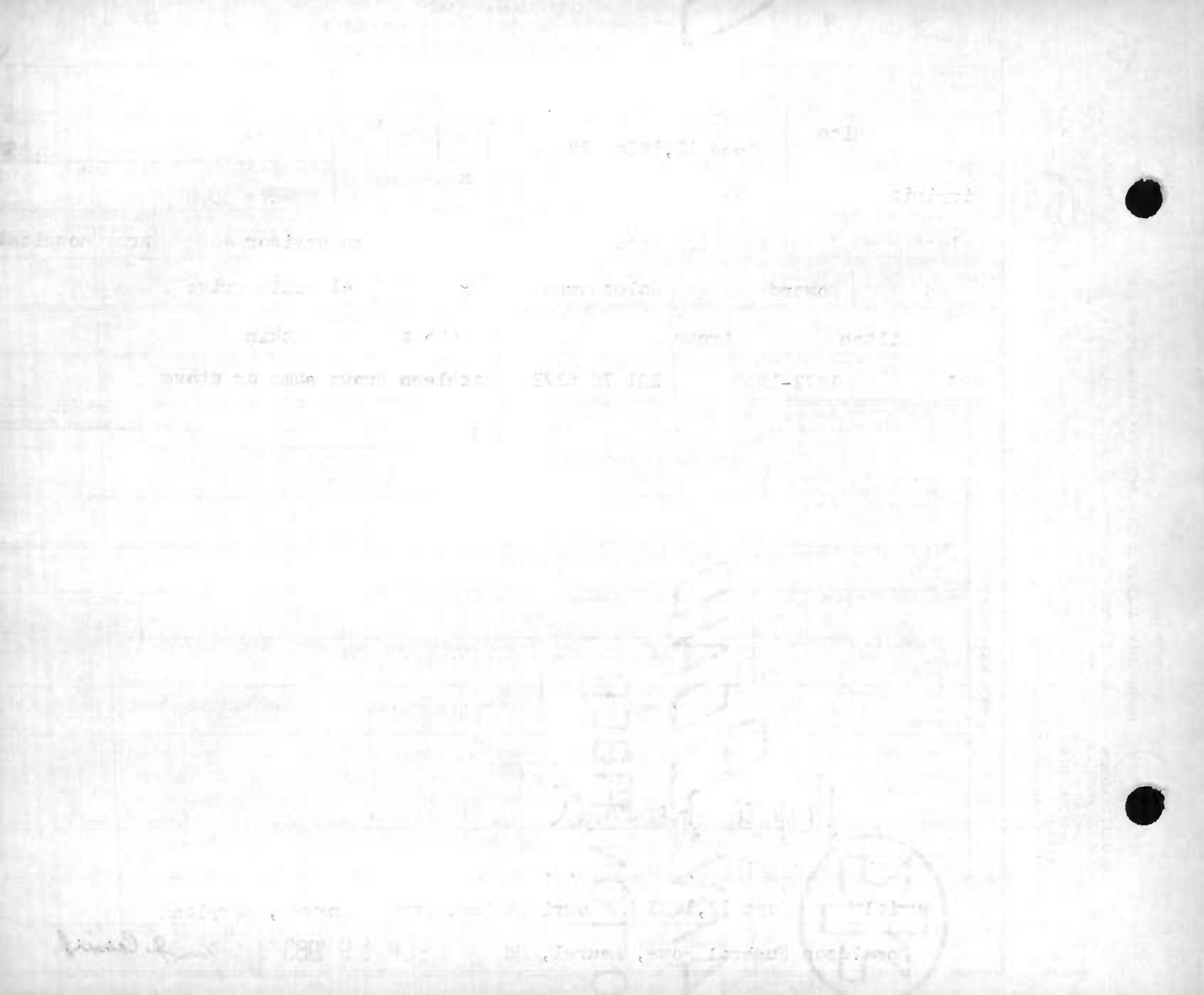


TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 IN YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FORWARDED TO THE DIVISION OF VITAL RECORDS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

BP

DHMH - 17
(VR A15 ME (5))
20M 4/82

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH										REG. NO. 24668	
1. DECEASED NAME (TYPE OR PRINT) STEVEN W. BROWN										2a. DATE KNOWN OF DEATH <input checked="" type="checkbox"/> MONTH DAY YEAR 9-8-83 19	
3. SEX M	4. RACE White	5. DATE OF BIRTH MONTH DAY YEAR June 11, 1954		6. AGE (IN YEARS LAST BIRTHDAY) 29 YRS.	IF UNDER 1 YR. MONTHS DAYS HOURS MIN		IF UNDER 24 HRS. MONTHS DAYS HOURS MIN		2c. DATE PRONOUNCED DEAD 9-8-83 19		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Virginia		7b. CITIZEN OF WHAT COUNTRY? USA			8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Howard County		2d. HOUR 5:55 P		
10. CITY OR TOWN OF DEATH Halethorpe		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 41 Reile Drive				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) supervisor A&D		12b. KIND OF BUSINESS OR INDUSTRY army hospital			
13a. STATE Md		13b. COUNTY Howard		13c. CITY OR TOWN Halethorpe		13d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO		13e. STREET ADDRESS 41 Reile Drive		21227	
14. FATHER'S NAME FIRST MIDDLE LAST Milton Brown					15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Rhoda Etkin						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) yes				16b. SOCIAL SECURITY NO. 1972-1980		17. INFORMANT ADDRESS Kathleen Brown same as above					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1 DEATH WAS CAUSED BY: 9554 IMMEDIATE CAUSE (a) Gunshot wound of head Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last. (b) (c) PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1:										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20. AUTOPSY? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO			
21a. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b. TIME OF INJURY 4:30 PM 9-8-83 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) self/inflicted					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) bedroom		21f. LOCATION CITY OR TOWN COUNTY STATE 41 Reile Drive Halethorpe, Maryland					
22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input checked="" type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> .											
ACTUAL SIGNATURE Margarete A. Korell				TITLE (SPECIFY) M.D. Assistant				DATE SIGNED 9-9-83			
EXAMINER'S NAME (TYPE OR PRINT) Margarita A. Korell, M.D.				ADDRESS 111 Penn Street							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE Sept 12, 1983		23c. NAME OF CEMETERY OR CREMATORY Meadowridge Mem. Park				23d. LOCATION CITY OR TOWN COUNTY STATE Dorsey, Maryland			
24. FUNERAL DIRECTOR NAME Donaldson Funeral Home, Laurel, Md						25a. DATE REC'D. BY REGISTRAR SEP 19 1983		25b. REGISTRAR'S SIGNATURE John J. Canfield			



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MEDICAL CERTIFICATION

1. DECEASED NAME (TYPE OR PRINT)				2a. DATE OF DEATH				2b. HOUR			
ALBERTA MAY BEAVER				09 15 83				5:15 P.M.			
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (IN YEARS LAST BIRTHDAY)		IF UNDER 1 YEAR		IF UNDER 24 HRS	
FEMALE		WHITE		MONTH DAY YEAR 08 20 99		84 YRS.		MONTHS DAYS		HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH					
MARYLAND		U.S.A.				HOWARD COUNTY MD.					
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY			
COLUMBIA		LORIEN NURSING HOME				SALESPERSON		BAKERY			
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)											
13a. STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS?		13e. STREET ADDRESS			
MARYLAND		HOWARD		COLUMBIA		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		10610 HIGH BEAM COURT, 21044			
14. FATHER'S NAME				15. MOTHER'S MAIDEN NAME							
FIRST MIDDLE LAST JOHN COOK				FIRST MIDDLE LAST LYDIA WHITMAN							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)				16b. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS					
NO				214-14-0112		BOBBIE E. DILLOW 10610 HIGH BEAM COURT COLUMBIA, MD.					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: 4360 IMMEDIATE CAUSE (a) <u>CRONIC ARREST</u>										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
DUE TO, OR AS A CONSEQUENCE OF (b) <u>VENTRICULUM ARRHYTHMIA</u>											
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (c) <u>CEREBROVASCULAR ACCIDENT</u>											
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (d) <u>PARKINSON'S DISEASE</u>											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?			
						YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)							
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET		CITY OR TOWN		COUNTY		STATE	
22a. I certify that (I) (the hospital) attended the deceased from <u>8-29</u> , 19 <u>80</u> , to <u>9-16</u> , 19 <u>83</u> , that (I) (we) lost saw the deceased alive on <u>9-6</u> , 19 <u>83</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE <u>Robert S. Goodwin</u>				DEGREE M.D.				ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 9-16-83	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) ROBERT S. GOODWIN, M.D.				22e. ADDRESS 7154 CRADLEROCK WAY; COLUMBIA, MARYLAND							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION CITY OR TOWN COUNTY STATE					
BURIAL		09-17-83		NEW CATHEDRAL		BALTIMORE CITY MARYLAND					
24. FUNERAL DIRECTOR NAME ADDRESS HUBBARD FUNERAL HOME, INC. 4107 WILKENS AVE.				25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE SEP 19 1983 <u>John J. Carver</u>					



[Faint, mostly illegible text and markings on lined paper, possibly a ledger or notebook page. Some words like "RECEIVED" and "174" are visible at the top.]

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

24670

1. FOR
STATE
REGISTRAR

WILLIE BURGESS

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) WILLIE A. BURGESS			2a. DATE OF DEATH MONTH 9 DAY 21 YEAR 83		2b. HOUR 8:30 AM
3. SEX Male	4. RACE Black	5. DATE OF BIRTH MONTH 10 DAY 14 YEAR 02		6. AGE (IN YEARS LAST BIRTHDAY) 80 YRS	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) South Carolina	7b. CITIZEN OF WHAT COUNTRY? U.S.A.	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Howard MD.	
10. CITY OR TOWN OF DEATH Columbia	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 9458 Pinecone Row		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Retired-Longshoreman-Dock Yards		12b. KIND OF BUSINESS OR INDUSTRY
13a. STATE md	13b. COUNTY Howard	13c. CITY OR TOWN Columbia	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e. STREET ADDRESS 9458 Pinecone Row 21045	
14. FATHER'S NAME FIRST Cephus MIDDLE LAST Burgess		15. MOTHER'S MAIDEN NAME FIRST Lula MIDDLE LAST Witherspoon			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. 239-05-4577		17. INFORMANT ADDRESS William Burgess Jr. Same as # 13	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardiorespiratory arrest 1550 DUE TO, OR AS A CONSEQUENCE OF (b) metastatic carcinoma DUE TO, OR AS A CONSEQUENCE OF (c) lymphoma					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH minutes ~ 1983
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: na					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (1) (this hospital) attended the deceased from _____, 19____, to _____, 19____, that (1) (we) lost saw the deceased alive or above (1) (we) (did) did not view the body after death.					
22b. SIGNATURE Alan G. Stahl, M.D.		DEGREE MD		22c. DATE SIGNED 9/21/83	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Alan G. Stahl, MD		22e. ADDRESS Columbia, Maryland 21044 Columbia Medical Plan			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 9/26/83		23c. NAME OF CEMETERY OR CREMATORY Mt. Lawn Cemetery	
23d. LOCATION CITY OR TOWN Philadelphia		COUNTY Pa.		STATE	
24. FUNERAL DIRECTOR Larry M. & Russell C. Witzke Funeral Homes P.A. 5555 Twin Knolls Road, Columbia, Md. 21045			25a. DATE REC'D. BY REGISTRAR SEP 27 1983		
25b. REGISTRAR'S SIGNATURE John J. Conner					

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the deceased, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

BP

9-11-38

TO THE DIRECTOR, BUREAU OF REVENUE
WASHINGTON, D. C.

FROM THE CHIEF, BUREAU OF REVENUE
WASHINGTON, D. C.

SUBJECT: [Illegible]

[Illegible text]

[Illegible text]

[Illegible text]

[Illegible text]

[Illegible text]

[Illegible text]

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										REG. NO.	
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Lillian B. Carey					2a. DATE OF DEATH MONTH DAY YEAR 9-3-83			2b. HOUR 8:00 P.M.			
3. SEX Female		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR 10-13-97		6. AGE (IN YEARS LAST BIRTHDAY) 85 YRS.		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland		7b. CITIZEN OF WHAT COUNTRY? United States		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Howard County, Columbia MD.					
10. CITY OR TOWN OF DEATH Columbia, Md.		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Lorien Nursing and Convalescent Home				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Housewife		12b. KIND OF BUSINESS OR INDUSTRY			
13a. STATE Maryland		13b. CITY OR TOWN Baltimore		13c. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		13d. STREET ADDRESS / ZIP CODE 36 Ridge Rd. / 21228					
14. FATHER'S NAME FIRST MIDDLE LAST late Chapman Billingsley Barber					15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST late Mary Jackson						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. 219-16-9227		17. INFORMANT Joseph Carey (son)		ADDRESS 9734 Old Annapolis Rd., Md.					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Probable Aspiration 4360 DUE TO, OR AS A CONSEQUENCE OF Vomiting large Amount Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } (b) abst. Dinner. DUE TO, OR AS A CONSEQUENCE OF (c) S/P CVA									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: Decubitus ulcer.											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)							
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE							
22a. I certify that (1) (this hospital) attended the deceased from 8-15-1983 to 9-3-1983 , that (2) (the) lost saw the deceased alive on 9-3-1983 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE A. Divakaruni				DEGREE MD ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 9-4-83					
22d. PHYSICIAN'S NAME (TYPE OR PRINT) A. Divakaruni				22e. ADDRESS 10606 Hickory Ridge Rd Columbia - MD 21044							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE Sept 7 '83		23c. NAME OF CEMETERY OR CREMATORY St Josephs Catholic		23d. LOCATION CITY OR TOWN COUNTY STATE Morganza Maryland					
24. FUNERAL DIRECTOR NAME Harry H Witzke 4112 Columbia Rd Ellicott City				25a. DATE REC'D. BY REGISTRAR SEP 6 1983		25b. REGISTRAR'S SIGNATURE [Signature]					



Houseside

late Mary Jackson

late Chapman Billingsley Barber

Marland

Honorable

St Joseph Catholic

Nov 7 '83

Marland

Harry H Wicks with Columbia Rd Elliott City

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1- FOR
STATE
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT)		FIRST	MIDDLE	LAST	2a. DATE OF DEATH		MONTH	DAY	YEAR	2b. HOUR	
Emma Castiglione					Sept. 2, 1983					10.30 p.m.	
3. SEX	4. RACE	5. DATE OF BIRTH		6. AGE (IN YEARS LAST BIRTHDAY)		IF UNDER 1 YEAR		IF UNDER 2 HRS.			
Female	White	MONTH DAY YEAR 12-10-1898		84 YRS.		MONTHS DAYS		HOURS MIN.			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)	7b. CITIZEN OF WHAT COUNTRY?	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH							
Italy	U.S.A.			Howard County MD.							
10. CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)				12b. KIND OF BUSINESS OR INDUSTRY		
Columbia, Md.	Lorien Nursing Home				DRESS MAKER				CLOTHING		
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)		13a. STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS?		13e. STREET ADDRESS / ZIP CODE	
MARYLAND		Howard		Elkridge		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		123 DEEP RUN PARKWAY		21227	
14. FATHER'S NAME		15. MOTHER'S MAIDEN NAME									
FIRST MIDDLE LAST PETER CAVALLARO		FIRST MIDDLE LAST ROSALIE Calabrese									
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO.		17. INFORMANT		ADDRESS					
NO		050-09-6929		ANNE PORCELLI		123 DEEP RUN PARKWAY					

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a) cardiac arrest APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
30 minute
 4292 DUE TO, OR AS A CONSEQUENCE OF
 (b) Atherosclerotic cardiovascular disease
 (years)
 DUE TO, OR AS A CONSEQUENCE OF
 (c)

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: (a)

chronic renal failure. Uncontrolled Diabetes mellitus.

19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?	
				YES <input type="checkbox"/> NO <input type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from <u>June 2, 1983</u> to <u>Sept 2, 1983</u> , that (I) (we) lost saw the deceased alive on <u>5.30 P.M. Sept 2, 1983</u> and that in my (our) opinion death occurred on the date and hour and from the causes stated above (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE		DEGREE		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED	
chong choon Han		M.D.				Sept. 2, 1983	
22d. PHYSICIAN'S NAME (TYPE OR PRINT)		22e. ADDRESS					
chong choon HAN.							

23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION CITY OR TOWN COUNTY STATE	
BURIAL		9/7/83		BALTIMORE NATIONAL		BALTIMORE MARYLAND	
24. FUNERAL DIRECTOR NAME		25a. DATE RECEIVED BY REGISTRAR		25b. REGISTRAR'S SIGNATURE			
WITZKE FUNERAL HOME OF Columbia		SEP 7 1983		John J. Lohr			
5555 TWIN KNOLLS Rd COLUMBIA MD.							

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the death certificate with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

BP

100-100000



12-10-11-12

U.S.A.

MISSISSIPPI VALLEY BANK

PETER CAVALLARO

ONE OF THE

CHARTERED

MEMBERS

OF THE

AMERICAN

ASSOCIATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified of this.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH					REG. NO.	
1. FOR STATE REGISTRAR			1. DECEASED NAME (TYPE OR PRINT)		2a. DATE OF DEATH	
			FIRST MIDDLE LAST ETHEL NOEL COHILL (COHILL)		MONTH DAY YEAR Sept 16, 1983	
3. SEX Female			4. RACE White		2b. HOUR 3P	
5. DATE OF BIRTH MONTH DAY YEAR 04 24 04			6. AGE (IN YEARS LAST BIRTHDAY) YRS 79		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) WASH DC.			7b. CITIZEN OF WHAT COUNTRY? U.S.A.		9. BALTIMORE CITY OR COUNTY OF DEATH Howard	
10. CITY OR TOWN OF DEATH N. Laurel			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 9515 Fulton Ave		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) HOUSEWIFE	
13a. STATE DC			13b. COUNTY None		12b. KIND OF BUSINESS OR INDUSTRY - N/A -	
14. FATHER'S NAME FIRST MIDDLE LAST Austin S. Noel			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Fannie Gay Seay		13c. STREET ADDRESS 4501 40th St NW	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) NO			16b. SOCIAL SECURITY NO. 577 664 4232		17. INFORMANT Son Paul D. Cohill	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardiac Arrest 4850 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last: (b) Bronch. pneumonia (c) 3 day			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 1 day		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 3 day	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)						
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from June 8 , 19 83 , to Sept 16 , 19 83 , that (I) (we) lost saw the deceased alive on Sept 16 , 19 83 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.						
22b. SIGNATURE Robert S. McEneaney MD			DEGREE MD		22c. DATE SIGNED 9/16/83	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Robert S. McEneaney MD			22e. ADDRESS 402 Main St, Laurel, Md. 20707			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial			23b. DATE SEP 19, 1983		23c. NAME OF CEMETERY OR CREMATORY NAT MEMORIAL PARK	
23d. LOCATION CITY OR TOWN COUNTY STATE FALLS CHURCH VIRGINIA			24. FUNERAL DIRECTOR NAME Robert A. D. S. R.			
24. FUNERAL DIRECTOR NAME DEVOL FUNERAL HOME.			ADDRESS 2222 Wisc. Ave		25a. DATE REC'D BY REGISTRAR OCT 7, 1983	
25b. REGISTRAR'S SIGNATURE John J. [Signature]			25c. REGISTRAR'S SIGNATURE John J. [Signature]			

(LINE) 14 3

RECEIVED

COLLEGE

DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

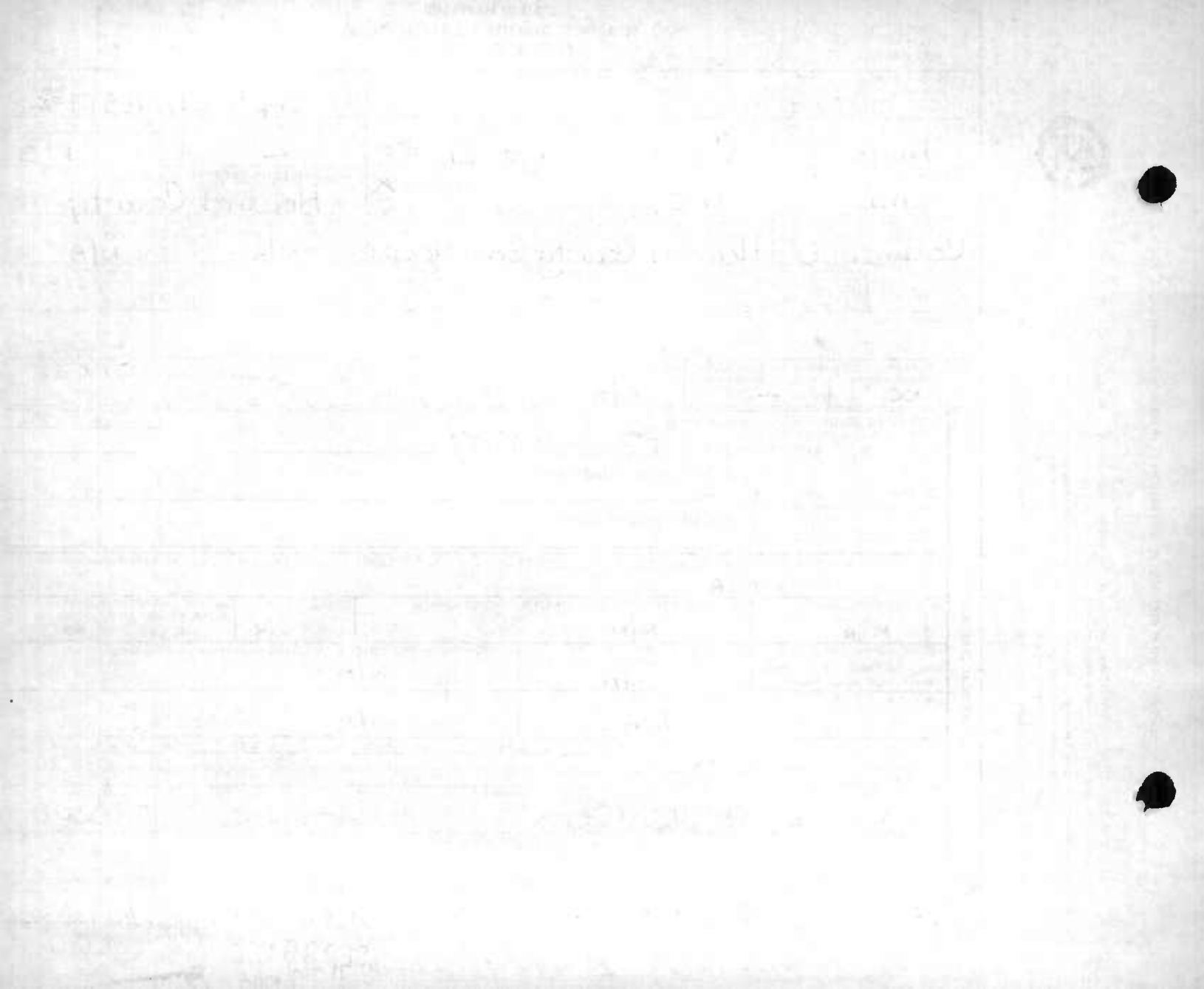
REG. NO.

1. DECEASED NAME (TYPE OR PRINT) Patrick J Davis			2a. DATE OF DEATH MONTH DAY YEAR Sept. 21, 1983			2b. HOUR 7 ³⁰ AM				
3. SEX Male		4. RACE Cauc		5. DATE OF BIRTH MONTH DAY YEAR Sept. 21, 1983		6. AGE (IN YEARS LAST BIRTHDAY) YRS MONTHS DAYS — — 13		IF UNDER 1 YEAR IF UNDER 24 HRS		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) MD		7b. CITIZEN OF WHAT COUNTRY? U.S.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Howard County MD				
10. CITY OR TOWN OF DEATH Columbia		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Howard County Gen. Hosp.				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) N/A		12b. KIND OF BUSINESS OR INDUSTRY N/A		
13a. STATE MD			13b. COUNTY Howard		13c. CITY OR TOWN Ellicott city		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS 9400 Parsley Drive 21043	
14. FATHER'S NAME FIRST MIDDLE LAST Roy Maxim Davis			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Patricia Lee Baker							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO			16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) N/A		17. INFORMANT ADDRESS Roy Davis 21043 9400 Parsley Drive					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: 7651 IMMEDIATE CAUSE (a) <u>PREMORTALITY</u> DUE TO, OR AS A CONSEQUENCE OF (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2. OTHER SIGNIFICANT CONDITIONS <u>CONTRIBUTING TO DEATH</u> BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) N/A										
19a. DATE OF OPERATION N/A			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED N/A			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. N/A 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) N/A				
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) N/A			21f. LOCATION STREET CITY OR TOWN COUNTY STATE N/A				
22a. I certify that (I) (this hospital) attended the deceased from 21 SEP 19 83 to 21 SEP 19 83, that (I) (we) lost saw the deceased alive on 21 SEP 19 83, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.										
22b. SIGNATURE Edward Cahill						DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 21 SEP 83		
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Edward Cahill						22e. ADDRESS 4790 montgomery Rd. Ellicott city, MD 21043				
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL			23b. DATE 9-24-83		23c. NAME OF CEMETERY OR CREMATORY Mt. View Cemetery		23d. LOCATION CITY OR TOWN COUNTY STATE Marriottsville Howard MD			
24. FUNERAL DIRECTOR NAME SLACK FUNERAL HOME			ADDRESS P.O. BOX 263 Ellicott City, MD 21043			25a. DATE REC'D BY REGISTRAR SEP 29 1983		25b. REGISTRAR'S SIGNATURE John J. Cahill		

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. It may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										REG. NO.		8 2 4 6 7 5 Sept. 15, 1983	
1. DECEASED NAME (TYPE OR PRINT) STEELMAN TAYLOR DAVIS										2a. DATE OF DEATH MONTH DAY YEAR 09 15 83		2b. HOUR A 6:30M	
3 SEX FEMALE		4 RACE WHITE CAUC.		5 DATE OF BIRTH MONTH DAY YEAR 08 14 1896		6 AGE (IN YEARS LAST BIRTHDAY) 87 YRS		7a. IF UNDER 1 YEAR MONTHS DAYS		7b. IF UNDER 74 HRS HOURS MIN.			
7c. BIRTHPLACE (STATE OR FOREIGN COUNTRY) DELAWARE		7d. CITIZEN OF WHAT COUNTRY? U.S.A.		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH KENT COUNTY MD.							
10 CITY OR TOWN OF DEATH CHESTERTOWN		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) MAGNOLIA HALL NSG HOME						12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) POSTAL CLERK		12b. KIND OF BUSINESS OR INDUSTRY			
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13b. STATE MD.										13c. COUNTY CECIL		13d. CITY OR TOWN EARLVILLE	
14 FATHER'S NAME FIRST MIDDLE LAST Elias D. Taylor										15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Lenora Catherine Taylor			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO		16b. SOCIAL SECURITY NO. 222-01-3316		17 INFORMANT ADDRESS 21919 Mildred Ludwig Earleville, Md.									
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) 4292 OLD AND RECURRENT STROKES DUE TO, OR AS A CONSEQUENCE OF (b) ASCVD Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (c) DUE TO, OR AS A CONSEQUENCE OF APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH years.													
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) CHRONIC URINARY TRACT INFECTION													
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)									
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE									
22a. I certify that (I) (the hospital) attended the deceased from 6-29-83 to 9-15-83, that (I) (we) last saw the deceased alive on 8-31-83, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.													
22b. SIGNATURE Harry Paul Ross		DEGREE MD		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>				22c. DATE SIGNED 9-15-83					
22d. PHYSICIAN'S NAME (TYPE OR PRINT)		22e. ADDRESS Chestertown, Md. 21620											
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Cremation		23b. DATE 9/16/83		23c. NAME OF CEMETERY OR CREMATORY Silverbrook Crematory				23d. LOCATION CITY OR TOWN COUNTY STATE Wilmington, Del.					
24. FUNERAL DIRECTOR NAME J. Willis Wells		ADDRESS Chestertown, Md.		25a. DATE REC'D. BY REGISTRAR SEP 20 1983		25b. REGISTRAR'S SIGNATURE J. Willis Wells							

Q 122A

CHARGE: LIBRARY TRUST INFECTION

2

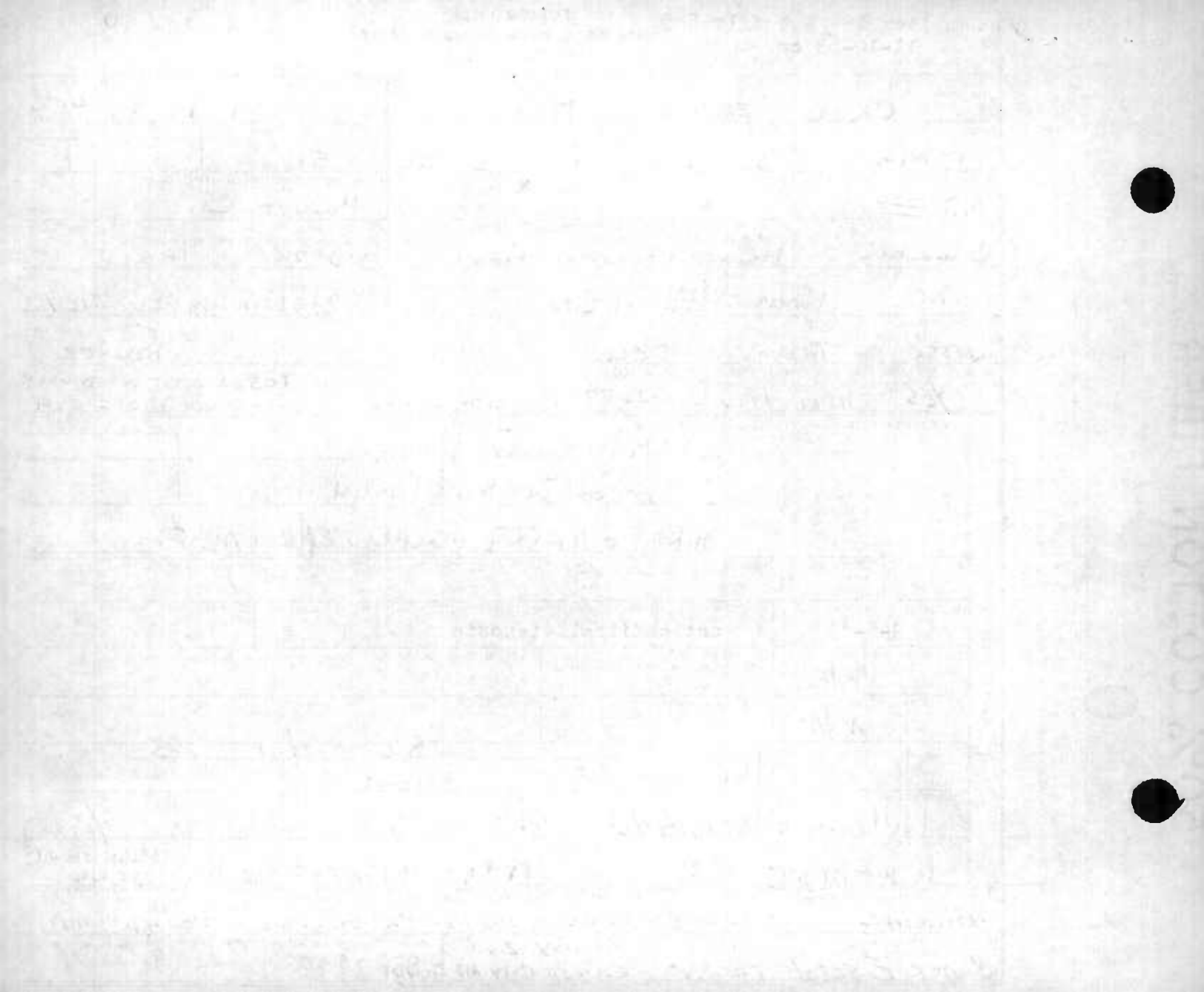
(Faint handwritten notes at the bottom of the page)

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 22 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

FOR Item 19a & b film 585		STATE OF MARYLAND		2 4 6 7 6	
1- STATE 11-10-83 en		DEPARTMENT OF HEALTH AND MENTAL HYGIENE		CERTIFICATE OF DEATH	
REGISTRAR		REG. NO.			
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Carl EDWARD Dell		2a. DATE OF DEATH MONTH DAY YEAR 9 19 83		2b. HOUR 4:00 PM	
3. SEX male	4. RACE Caucasian	5. DATE OF BIRTH MONTH DAY YEAR 12 3 26		6. AGE (IN YEARS LAST BIRTHDAY) 56 YRS IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN.	
7a. BIRTHPLACE (COUNTRY) MD. DE	7b. CITIZEN OF WHAT COUNTRY? U.S.	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Howard Co. MD.	
10. CITY OR TOWN OF DEATH Columbia	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Howard Co. Gen. Hosp.		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) INSPECTOR		12b. KIND OF BUSINESS OR INDUSTRY B.G.F.E.
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) MD.		13b. COUNTY Howard	13c. CITY OR TOWN Ellicott City	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST JESSE Thomas DELL		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LEONA BECKER		13e. STREET ADDRESS 9233 Windyway 21043	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) YES		16b. SOCIAL SECURITY NO. 1944-1946 215-22-3777		17. INFORMANT TIMOTHY J. DELL ADDRESS 10522 EAST WIND WAY COLUMBIA MD 21044	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardiogenic Shock. 3940 DUE TO, OR AS A CONSEQUENCE OF (b) Coronary Heart Failure DUE TO, OR AS A CONSEQUENCE OF (c) mitral & aortic valve replacement. APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)					
19a. DATE OF OPERATION 9-6-83		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED Aortic & Mitral Stenosis		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>					
21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING TO DEATH (IF EITHER NOTIFY MEDICAL EXAMINER) N/A		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input checked="" type="checkbox"/> N/A		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from 82 , to 9/19 , 19 83 , that (I) (we) lost saw the deceased alive on 9/19 , 19 83 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. Natural					
22b. SIGNATURE William Flowers MD		DEGREE MD		22c. DATE SIGNED 9/19/83	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Wm Flowers MD		22e. ADDRESS 10802 Hickory Ridge Rd Columbia MD 21044			
23a. BURIAL, CREMATION, REMOVAL (TYPE OF) Burial		23b. DATE 9-22-83		23c. NAME OF CEMETERY OR CREMATORY MEADOWRIDGE MEM. PK. ELK RIDGE	
23d. LOCATION CITY OR TOWN COUNTY STATE HOWARD MD.					
24. FUNERAL DIRECTOR NAME SNACK FUNERAL HOME		ADDRESS P.O. Box 268 ELICOTT CITY MD 21043		25a. DATE REC'D. BY REGISTRAR SEP 21 1983	
				25b. REGISTRAR'S SIGNATURE John J. Connel	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

FOR
STATE
REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) BEATRICE (BETTY) EMERY		2a. DATE OF DEATH MONTH DAY YEAR 9 22 85		2b. HOUR 11 15 P M	
3. SEX Female	4. RACE White	5. DATE OF BIRTH MONTH DAY YEAR March 1, 1915		6. AGE (IN YEARS LAST BIRTHDAY) 68 YRS	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Canada	7b. CITIZEN OF WHAT COUNTRY? Canada	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Howard County MD.	
10. CITY OR TOWN OF DEATH Columbia	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Howard County General Hospital		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Housewife		12b. KIND OF BUSINESS OR INDUSTRY
13a. STATE Maryland		13b. COUNTY Howard	13c. CITY OR TOWN Ellicott City	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST late George Blaikie		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST late Cora Wilson			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. 217 48 3604		17. INFORMANT ADDRESS George Emery 3133 A Normandy Woodd DR. 21043	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) METASTATIC Breast Carcinoma 1749 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ DUE TO, OR AS A CONSEQUENCE OF PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a): CHRONIC OBSTRUCTIVE Lung Disease.					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH YEARS
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from 9-20 , 19 85 , to 9-22 , 19 85 , that (I) (we) last saw the deceased alive on 9-22 , 19 85 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE Gregory D. Rennie M.D.		DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 9-22-85	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) LARRY I. LEVINE, M.D.		22e. ADDRESS 10802 Hickory Ridge Rd, Col, Md. 21044			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE SEPT 24, 1983		23c. NAME OF CEMETERY OR CREMATORY Crestlawn	
23d. LOCATION CITY OR TOWN COUNTY STATE Howard Maryland		24. FUNERAL DIRECTOR NAME ADDRESS Harry H Witzke 4112 Columbia Road Ellicott City			
25a. DATE REC'D. BY REGISTRAR SEP 26 1983		25b. REGISTRAR'S SIGNATURE John J. Conner			

BP

HARRY H WISSE 1113 Columbia Elliptic City

Born SEP 24, 1907 Greenville

Howard Maryland

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OFFICE OF THE CLERK OF THE DISTRICT COURT

AT BALTIMORE, MARYLAND

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FILED IN BOOK 10, PAGE 10

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 3 2 4 6 7 8

1. FOR
STATE
REGISTRAR

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) John EDWARD EVANS			2a. DATE OF DEATH MONTH 9 DAY 30 YEAR 83		2b. HOUR 6:24 A M
3. SEX male	4. RACE Black	5. DATE OF BIRTH MONTH 1 DAY 17 YEAR 13		6. AGE (IN YEARS LAST BIRTHDAY) 70 YRS.	IF UNDER 1 YEAR MONTHS DAYS
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Mass.	7b. CITIZEN OF WHAT COUNTRY? USA	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH HOWARD MD.	
10. CITY OR TOWN OF DEATH Columbia	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Howard County General		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Minister		12b. KIND OF BUSINESS OR INDUSTRY
13a. STATE MD		13b. COUNTY HOWARD	13c. CITY OR TOWN Columbia	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	13e. STREET ADDRESS 21046 9709 Clock Tower Lane
14. FATHER'S NAME FIRST Charles MIDDLE Evans LAST 			15. MOTHER'S MAIDEN NAME FIRST Edith MIDDLE Smith LAST 		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) Yes		16b. SOCIAL SECURITY NO. 112-05-2793		17. INFORMANT Luella (wife) ADDRESS Same	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardiac arrest 4149 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last: (b) Severe Coronary Artery Disease DUE TO, OR AS A CONSEQUENCE OF (c) 					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 11a:					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (he) (this hospital) attended the deceased from 9-30-83 to 9-30-83 , that (I) (we) last saw the deceased alive on 4 19 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE A. Divakaruni		DEGREE MD ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 9-30-83	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) A. DIVAKARUNI		22e. ADDRESS 10806 Hickory Ridge Rd Columbia, MD, 21046			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial	23b. DATE 10-4-83	23c. NAME OF CEMETERY OR CREMATORY Moses Cemetery		23d. LOCATION CITY OR TOWN COUNTY STATE Northon Pr Geo Md.	
24. FUNERAL DIRECTOR NAME George R. Snowden ADDRESS 246 N. Wash. St. Rockville, Md.		DATE REC'D BY REGISTRAR 4 1983 REGISTRAR'S SIGNATURE John J. Connel			

58 81 235 30 1
IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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BP

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified or called.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH				REG. NO.			
1. STATE REGISTRAR				1. DECEASED NAME (TYPE OR PRINT)			
2. DATE OF DEATH				3. SEX			
3. SEX				4. RACE			
4. RACE				5. DATE OF BIRTH			
5. DATE OF BIRTH				6. AGE (IN YEARS LAST BIRTHDAY)			
6. AGE (IN YEARS LAST BIRTHDAY)				7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)				7b. CITIZEN OF WHAT COUNTRY?			
7b. CITIZEN OF WHAT COUNTRY?				8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			
8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>				9. BALTIMORE CITY OR COUNTY OF DEATH			
9. BALTIMORE CITY OR COUNTY OF DEATH				10. CITY OR TOWN OF DEATH			
10. CITY OR TOWN OF DEATH				11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)			
11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			
12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)				12b. KIND OF BUSINESS OR INDUSTRY			
12b. KIND OF BUSINESS OR INDUSTRY				13a. INSIDE CITY LIMITS?			
13a. INSIDE CITY LIMITS?				13b. STREET ADDRESS			
13b. STREET ADDRESS				14. FATHER'S NAME			
14. FATHER'S NAME				15. MOTHER'S MAIDEN NAME			
15. MOTHER'S MAIDEN NAME				16a. WAS DECEASED EVER IN U.S. ARMED FORCES?			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES?				16b. SOCIAL SECURITY NO.			
16b. SOCIAL SECURITY NO.				17. INFORMANT ADDRESS			
17. INFORMANT ADDRESS				18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
PART I. DEATH WAS CAUSED BY:				IMMEDIATE CAUSE (a)			
IMMEDIATE CAUSE (a)				DUE TO, OR AS A CONSEQUENCE OF			
DUE TO, OR AS A CONSEQUENCE OF				DUE TO, OR AS A CONSEQUENCE OF			
DUE TO, OR AS A CONSEQUENCE OF				PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1:			
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1:				19a. DATE OF OPERATION			
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			
19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY?			
20a. AUTOPSY?				20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?			
20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?				21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR			
21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR				21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)				21d. INJURY OCCURRED			
21d. INJURY OCCURRED				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			
21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)				21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
21f. LOCATION STREET CITY OR TOWN COUNTY STATE				22a. I certify that (I) (this hospital) attended the deceased from above (I) (we) (did) (did not) view the body after death.			
22a. I certify that (I) (this hospital) attended the deceased from above (I) (we) (did) (did not) view the body after death.				22b. DATE SIGNED			
22b. DATE SIGNED				22c. DATE SIGNED			
22c. DATE SIGNED				22d. ADDRESS			
22d. ADDRESS				23a. BURIAL, CREMATION, REMOVAL (SPECIFY)			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)				23b. DATE			
23b. DATE				23c. NAME OF CEMETERY OR CREMATORY			
23c. NAME OF CEMETERY OR CREMATORY				23d. LOCATION CITY OR TOWN COUNTY STATE			
23d. LOCATION CITY OR TOWN COUNTY STATE				24. FUNERAL DIRECTOR NAME ADDRESS			
24. FUNERAL DIRECTOR NAME ADDRESS				25a. DATE REC'D. BY REGISTRAR			
25a. DATE REC'D. BY REGISTRAR				25b. REGISTRAR'S SIGNATURE			

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE																								
1 - STATE REGISTRAR GEORGE JOSEPH HAKER					CERTIFICATE OF DEATH																			
FOR					REG. NO.																			
1. DECEASED NAME (TYPE OR PRINT)					2a. DATE OF DEATH					2b. HOUR														
FIRST MIDDLE LAST GEORGE JOSEPH HAKER					MONTH DAY YEAR 9 7 83					6 45 P M														
3. SEX			4. RACE		5. DATE OF BIRTH			6. AGE (IN YEARS LAST BIRTHDAY)			IF UNDER 1 YEAR		IF UNDER 24 HRS											
MALE			White		MONTH DAY YEAR 5 10 09			74 YRS.			MONTHS DAYS		HOURS MIN.											
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)			7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH																
Maryland			U.S.A.					HOWARD COUNTY MD.																
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)							12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY											
COLUMBIA			HOWARD COUNTY GEN. HOSP							Carpenter - Bld. Contractor														
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)					13b. COUNTY					13c. CITY OR TOWN					13d. INSIDE CITY LIMITS?					13e. STREET ADDRESS				
MD					HOWARD					COLUMBIA					YES <input type="checkbox"/> NO <input type="checkbox"/>					21043 7931 OLD MONTGOMERY RD				
14. FATHER'S NAME					15. MOTHER'S MAIDEN NAME																			
FIRST MIDDLE LAST George Haker					FIRST MIDDLE LAST Anne G. Wess																			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)					16b. SOCIAL SECURITY NO.					17. INFORMANT					ADDRESS									
No					217-16-8848					Mrs. Virginia Haker					Same as # 13									
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)															APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH									
PART I. DEATH WAS CAUSED BY:																								
IMMEDIATE CAUSE (a) Septis																								
4360 DUE TO, OR AS A CONSEQUENCE OF (b) decubitus ulcers																								
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.																								
DUE TO, OR AS A CONSEQUENCE OF (c) stroke																								
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: (a)																								
19a. DATE OF OPERATION					19b. CONDITION FOR WHICH OPERATION WAS PERFORMED					20a. AUTOPSY?					20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?									
										YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					YES <input type="checkbox"/> NO <input type="checkbox"/>									
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)					21b. TIME OF INJURY					21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)														
					HOUR A.M. MONTH DAY YEAR P.M. 19																			
21d. INJURY OCCURRED					21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)					21f. LOCATION														
WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK										STREET CITY OR TOWN COUNTY STATE														
22a. I certify that (I) (this hospital) attended the deceased from 9/7 , 19 83 , to 9/12 , 19 83 , that (I) (we) lost saw the deceased alive on 9/7 , 19 83 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.																								
22b. SIGNATURE										DEGREE					22c. DATE SIGNED									
Gary C. Prode, MD										ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>					9/7/83									
22d. PHYSICIAN'S NAME (TYPE OR PRINT)										22e. ADDRESS														
Gary C. Prode, MD										9380 Agate Road Pk														
23a. BURIAL, CREMATION, REMOVAL					23b. DATE					23c. NAME OF CEMETERY OR CREMATORY					23d. LOCATION									
Burial					9/12/83					Crestlawn Cemetery					Marriottsville Md.									
24. FUNERAL DIRECTOR															25a. DATE REC'D. BY REGISTRAR					25b. REGISTRAR'S SIGNATURE				
Leroy M. & Russell C. Witzke Funeral Homes P.A.															SEP 13 1983					John J. Gosh				
5555 Twin Knolls Road, Columbia, Md. 21045																								

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH				REG. NO.	
1. DECEASED NAME (TYPE OR PRINT) Alois Hermann			2a. DATE OF DEATH MONTH DAY YEAR September 11, 1983		2b. HOUR M
3. SEX Male	4. RACE White	5. DATE OF BIRTH MONTH DAY YEAR January 29, 1903		6. AGE (IN YEARS LAST BIRTHDAY) 80 YRS IF UNDER 1 YEAR: MONTHS DAYS IF UNDER 24 HRS: HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Germany	7b. CITIZEN OF WHAT COUNTRY? U.S.A.	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Howard County MD	
10. CITY OR TOWN OF DEATH Columbia	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Howard County General Hospital		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Retired Tailor Cutter		12b. KIND OF BUSINESS OR INDUSTRY
13a. STATE Maryland		13b. COUNTY Howard	13c. CITY OR TOWN Ellicott City	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST late unknown		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST late unknown			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) No		16b. SOCIAL SECURITY NO. 212 03 7831		17. INFORMANT ADDRESS Mrs Rose Herrmann 3322 Coventry Ct 21043	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1: DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Sudden Cardiac death 4292 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost (b) Arteriosclerotic Cardiovascular disease (presumed) DUE TO, OR AS A CONSEQUENCE OF (c)					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2: OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a)					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
21d. INJURY OCCURRED WHERE <input type="checkbox"/> NOT WHERE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from 7/1/80 19 to 9/11 19 83 , that (I) (we) last saw the deceased alive on 3/11 19 83 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE Brad J. Cooper, M.D.		DEGREE		22c. DATE SIGNED 9/12/83	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Brad J. Cooper, M.D.		22e. ADDRESS 3459 St. Johns Lane Ellicott City, Md. 21043			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE Sept 14, 1983		23c. NAME OF CEMETERY OR CREMATORY Loudon Park	
23d. LOCATION CITY OR TOWN COUNTY STATE Baltimore Maryland					
24. FUNERAL DIRECTOR NAME ADDRESS Harry H Witzke 4112 Columbia Rd Ellicott City		25a. DATE REC'D. BY REGISTRAR SEP 13 1983			
25b. REGISTRAR'S SIGNATURE <i>[Signature]</i>					

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Alola	Howard	September 11, 1983
Male	White	January 28, 1903
Germany	U.S.A.	Howard County
Columbia	Howard County General Hospital	Retired Tailor Cutter
Maryland	Howard	Ellicott City
3322 Coventry Ct 21043		
late unknown	late unknown	
No	332 03 7831 Mrs Rose Hermann 3322 Coventry Ct 21043	

Harry H White 4112 Columbia Ellicott City
 Sept 14, 1983 London Park
 Baltimore Maryland

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH					REG. NO.	
1. DECEASED NAME (TYPE OR PRINT) GLADYS E. KELLY			2a. DATE OF DEATH MONTH DAY YEAR 9 15 83		2b. HOUR 9:10 ^P M	
3. SEX Female		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR 4 5 05		6. AGE (IN YEARS LAST BIRTHDAY) 78 YRS
7a. BIRTHPLACE (COUNTRY) Maryland		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Howard County MD.
10. CITY OR TOWN OF DEATH Columbia		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Lorien Nursing Home		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Homemaker		12b. KIND OF BUSINESS OR INDUSTRY ---
13a. STATE Maryland		13b. COUNTY Baltimore		13c. STREET ADDRESS / ZIP CODE 2608 W. Patapaso Ave. 1-B 21230		
14. FATHER'S NAME FIRST MIDDLE LAST John Edward Morris			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Lillie Vickers			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) NO		16b. SOCIAL SECURITY NO. 216-03-2102		17. INFORMANT ADDRESS William H. Garmer 21043 3110 Paulskirk Drive		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>HISTIOCYTIC LYMPHOMA</u> <u>2000</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____						APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <u>ACUTE MYOCARDIAL INFARCTION</u>						
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)		
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE		
22a. I certify that (I) (this hospital) attended the deceased from <u>9:8</u> , 19 <u>83</u> , to <u>9:15</u> , 19 <u>83</u> , that (I) (we) lost saw the deceased alive on <u>9:8</u> , 19 <u>83</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.						
22b. SIGNATURE <u>Krishna P. Kumar</u>		DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED <u>9:15:83</u>		
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <u>KRISHNA P. KUMAR</u>		22e. ADDRESS <u>11065 LITTLE PATUXENT PARKWAY COLUMBIA MD 21046</u>				
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 9/19/83		23c. NAME OF CEMETERY OR CREMATORY Meadowridge Mem. Pk.		23d. LOCATION CITY OR TOWN COUNTY STATE Elkridge Howard Md.
24. FUNERAL DIRECTOR NAME Hubbard Funeral Home, Inc.		ADDRESS 4107 Wilkens Ave.		25a. DATE RECD. BY REGISTRAR SEP 19 1983		25b. REGISTRAR'S SIGNATURE <u>John J. Garmer</u>

BP



STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEASED NAME (TYPE OR PRINT)		FIRST MIDDLE LAST		2a. DATE OF DEATH		MONTH DAY YEAR		2b. HOUR	
Herbert		Herbert Bleidig Leidig		9		8 83		5:25 PM	
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (IN YEARS LAST BIRTHDAY)		7. IF UNDER 1 YEAR	
Male		Caucasian		6 25 14		69		MONTHS DAYS HOURS MIN	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH		10. MD	
Maryland		USA				Howard Co			
11. CITY OR TOWN OF DEATH		12. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		13a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		13b. KIND OF BUSINESS OR INDUSTRY			
Columbia Md		Howard Co. General Hospital							
14. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)		15a. STATE		15b. COUNTY		15c. CITY OR TOWN		15d. INSIDE CITY LIMITS?	
Md		Howard		Laurel		YES <input type="checkbox"/> NO <input type="checkbox"/>		15e. STREET ADDRESS	
								20707	
16a. FATHER'S NAME		16b. MOTHER'S MAIDEN NAME		17. INFORMANT		ADDRESS		20707	
late Frederick C. Leidig		late Mary Jane		Mrs Carol Eckert		10613 GraeLOCK RD		Laurel	
18a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		18b. SOCIAL SECURITY NO (IF YES, GIVE WAR OR DATES)		19. INFORMANT		ADDRESS		20707	
Yes		W.W.11		212 09 3399		Mrs Carol Eckert		10613 GraeLOCK RD Laurel	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 4511		19. DUE TO, OR AS A CONSEQUENCE OF (b) possible pulmonary embolus		20. DUE TO, OR AS A CONSEQUENCE OF (c) possible deep venous thrombosis; myocardial infarction		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		46 mins	
4511								46 mins	
21. PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I:									
21a. DATE OF OPERATION		21b. CONDITION FOR WHICH OPERATION WAS PERFORMED		21c. AUTOPSY?		21d. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?			
				YES <input type="checkbox"/> NO <input type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>			
22a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		22b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR		22c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)					
		P.M. 19							
23a. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		23b. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		23c. LOCATION STREET CITY OR TOWN COUNTY STATE					
24. I certify that (I) (this hospital) attended the deceased from 9/5, 19 83, to 9/8, 19 83, that (I) (we) last saw the deceased alive on 9/8, 19 83, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above (I) (we) (did) (did not) view the body after death.									
25a. SIGNATURE		25b. DEGREE		25c. ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		25d. DATE SIGNED		9/8/83	
STEPHEN A. VALENTINO									
26a. PHYSICIAN'S NAME (TYPE OR PRINT)		26b. ADDRESS							
STEPHEN A. VALENTINO		Howard County General Hosp.							
27a. BURIAL, CREMATION, REMOVAL (SPECIFY)		27b. DATE		27c. NAME OF CEMETERY OR CREMATORY		27d. LOCATION CITY OR TOWN COUNTY STATE			
Burial		SEpt 12 1983		Loudon Park		Baltimore Maryland			
28. FUNERAL DIRECTOR NAME		28b. ADDRESS		29. DATE REC'D. BY REGISTRAR		30. REGISTRAR'S SIGNATURE			
Harry H Witzke		4112 Columbia Rd Ellicott City		SEP 9 1983		John J. Smith			

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Please keep it until it is retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the health officer with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

Herbert A. Leiding

Male

Maryland

20703

Late Mary Jane

Late Frederick G. Leiding

20707

Yes W.V.I. 212 09 3399 Mrs Carol Robert 10013 Gravelton Rd Laurel

Burial Sept 12 1983 London Park

Baltimore Maryland

Harry H. White III Columbia Rd Ellicott City



STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1- FOR
STATE
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Josephine H. Lewis			2a. DATE OF DEATH MONTH DAY YEAR 9 12 83		2b. HOUR P. M.		
3. SEX Female		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR 10 1 18		6. AGE (IN YEARS LAST BIRTHDAY) 64 YRS. IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Howard County MD.	
10. CITY OR TOWN OF DEATH Ellicott City		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 10327 Burnside Drive				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Disability Examiner	
12b. KIND OF BUSINESS OR INDUSTRY Social Security Adm.							
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE Maryland				13b. COUNTY Howard		13c. CITY OR TOWN Ellicott City	
13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				13e. STREET ADDRESS 10327 Burnside Drive 21043			
14. FATHER'S NAME FIRST MIDDLE LAST Anthony Stolarski				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Helen Dombroski			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO		16b. SOCIAL SECURITY NO. 215-09-5393		17. INFORMANT ADDRESS Gregory W. Lewis 10327 Burnside Dr. 21043			

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART 1. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a) **Recurrent Carcinoma of Colon**

1539
Conditions, if any, which
gave rise to immediate
cause (a), stating the
underlying cause last.

DUE TO, OR AS A CONSEQUENCE OF

(b)

DUE TO, OR AS A CONSEQUENCE OF

(c)

APPROXIMATE INTERVAL
BETWEEN ONSET AND DEATH

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 11a

19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from Nov 16, 19 82 to Sept 9, 19 83 , that (I) (we) last saw the deceased alive on Sept 9, 19 83 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE H. Charles Kim		DEGREE		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 9/13/83	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) H. Charles Kim				22e. ADDRESS 1134 York Road			

23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 9/16/83		23c. NAME OF CEMETERY OR CREMATORY Loudon Park Cemetery		23d. LOCATION CITY OR TOWN COUNTY STATE Baltimore Maryland	
24. FUNERAL DIRECTOR NAME Hubbard Funeral Home, Inc. 4107 Wilkens Ave.				25a. DATE REC'D. BY REGISTRAR SEP 14 1983		25b. REGISTRAR'S SIGNATURE John J. Smith	

BP

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.



TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR RECORDS. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 24 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH										REG. NO.	
1. FOR STATE REGISTRAR											
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Burton McKinley Marlowe						2a. DATE KNOWN OF DEATH MONTH DAY YEAR 9 10 19 83			2b. HOUR M 4:15A		
3. SEX Male		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR 12 28 26		6. AGE (IN YEARS LAST BIRTHDAY) 56 YRS.		7. IF UNDER 1 YR. MONTHS DAYS HOURS MIN.		2c. DATE PRONOUNCED DEAD MONTH DAY YEAR 9 10 19 83	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Washington, D.C.				7b. CITIZEN OF WHAT COUNTRY? U.S.A.				8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Howard County, MD.	
10. CITY OR TOWN OF DEATH Lisbon				11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Rts. 70 & 94				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Truck Driver		12b. KIND OF BUSINESS OR INDUSTRY Trucking	
13a. STATE California						13b. COUNTY Orange		13c. CITY OR TOWN Anaheim		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST John Marlowe						15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Janie Burton					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) Yes				16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) Korean		17. INFORMANT W. E. Pennington,				ADDRESS Anaheim, Ca. 1617 W. LaPalma Ave.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: 8/20 IMMEDIATE CAUSE (a) Thermal injuries DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (c) stating the underlying cause last. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a).											
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?						20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
21a. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR 3 XXX 9 10 19 83		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2) Driver in tractor-trailer/truck impact					
21d. INJURY OCCURRED WHILE <input checked="" type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) road		21f. LOCATION STREET CITY OR TOWN COUNTY STATE Rts. 70 & 94 Howard, Md.					
22a. I certify that I took charge of the remains described above, held on death resulted from: <input type="checkbox"/> Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> .											
ACTUAL SIGNATURE Thomas D. SMith, M.D.				TITLE (SPECIFY) Deputy Chief				DATE SIGNED 9/10/83			
EXAMINER'S NAME (TYPE OR PRINT)				ADDRESS 111 Penn St. Balto., MD.							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Removal/Burial				23b. DATE 09-15-83		23c. NAME OF CEMETERY OR CREMATORY Riverside National Cem.				23d. LOCATION CITY OR TOWN COUNTY STATE Riverside Riverside Ca.	
24. FUNERAL DIRECTOR NAME Balto., Md. ADDRESS 21229 Hubbard Funeral Home, Inc. 4107 Wilkens Ave.						25a. DATE REC'D BY REGISTRAR SEP 16 1983		25b. REGISTRAR'S SIGNATURE John J. Chief			

1754
(34)

[Faint, illegible handwritten text]

(34)

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. FOR
STATE
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) Thomas Hunt Mayfield			2a. DATE OF DEATH MONTH DAY YEAR 9/8/83		2b. HOUR 852 AM
2. SEX Male	4. RACE White	5. DATE OF BIRTH MONTH DAY YEAR 12 13 06	6. AGE (IN YEARS, LAST BIRTHDAY) 76 YRS		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) MARYLAND	7b. CITIZEN OF WHAT COUNTRY? U.S.	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9. BALTIMORE CITY OR COUNTY OF DEATH Howard MD.		
10. CITY OR TOWN OF DEATH Columbia	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) HC & Hospital		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Judge - Attorney	12b. KIND OF BUSINESS OR INDUSTRY Judicial	
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13b. STATE MD 13c. COUNTY Howard 13d. CITY OR TOWN Ellicott City			13e. STREET ADDRESS 3634 Underwood Dr.		
14. FATHER'S NAME FIRST MIDDLE LAST Thomas Hunt Mayfield SR			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Edna Brerly		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) yes		16b. SOCIAL SECURITY NO. (IF YES, GIVE DATE OF BIRTH) 213 01 69 32	17. INFORMANT NAME ADDRESS Ms. Elizabeth Mayfield 3634 Underwood Dr. Ellicott City MD 21042		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) pneumonia DUE TO, OR AS A CONSEQUENCE OF (b) carcinoma of the Lung. DUE TO, OR AS A CONSEQUENCE OF (c) CONDITIONS, if any, which gave rise to immediate cause (a), stating the underlying cause last. 1629					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. INJURY OR DISEASE (IF EITHER, NOTIFY MEDICAL EXAMINER) NIA		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)	
21d. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) AT HOME		21e. LOCATION STREET CITY OR TOWN COUNTY STATE 10802 Hickman Rd. Ellicott City Howard MD			
22a. I certify that (I) (this hospital) attended the deceased from 9/8 , 19 83 , to 9/8 , 19 83 , that (I) (we) lost saw the deceased alive on 9/8 , 19 83 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE William F. Flowers MD		DEGREE MD		22c. DATE SIGNED 9/8/83	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) WM FLOWERS MD.		22e. ADDRESS 10802 Hickman Rd. Ellicott City Howard MD			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL	23b. DATE 9-10-83	23c. NAME OF CEMETERY OR CREMATORY ST. JOHN'S Cem.		23d. LOCATION CITY OR TOWN COUNTY STATE Ellicott City Howard MD	
24. FUNERAL DIRECTOR NAME SLACK FUNERAL HOME		ADDRESS Re Box 268 Ellicott City Md 21042		25a. DATE REC'D. BY REGISTRAR SEP 13 1983	

The medical examiner must be notified at once.

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.



2000-2001

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified of this.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH				REG. NO.			
1. FOR STATE REGISTRAR				2. DATE OF DEATH MONTH DAY YEAR			
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Laura Merson				September 6, 1983 10:30 PM			
3. SEX Female		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR July 26, 1944		6. AGE (IN YEARS LAST BIRTHDAY) 39 YRS	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Howard MD.	
10. CITY OR TOWN OF DEATH xx Jessup Hanover		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 7604 Rae Road		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) housewife		12b. KIND OF BUSINESS OR INDUSTRY home	
13a. STATE Md				13b. CITY OR TOWN Howard		13c. STREET ADDRESS 7604 Rae Road 21076	
14. FATHER'S NAME FIRST MIDDLE LAST William Harman Burns				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Arsula Williams			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) no				16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES)		17. INFORMANT ADDRESS Paul Merson same as above	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Metastatic Breast carcinoma to</u> <u>1749</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last: DUE TO, OR AS A CONSEQUENCE OF (b) <u>Bones & Lungs</u> DUE TO, OR AS A CONSEQUENCE OF (c) _____ APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH _____							
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) _____							
19a. DATE OF OPERATION -		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED -		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from <u>4-6</u> 19 <u>81</u> to <u>Sept</u> 19 <u>83</u> , that (I) (we) lost saw the deceased alive on <u>8-22</u> 19 <u>83</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE <u>A. Shamim MD</u>				DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 9-7-83	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) AHMAD SHAMIM				22e. ADDRESS 200 Ft. Meade Rd., Laurel, Md. 20707			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE Sept 10, 1983		23c. NAME OF CEMETERY OR CREMATORY Meadowridge Memorial		23d. LOCATION CITY OR TOWN COUNTY STATE Park Dorsey, Md	
24. FUNERAL DIRECTOR NAME Donaldson Funeral Home, ADDRESS Laurel, Md				25a. DATE REC'D. BY REGISTRAR SEP 13 1983		25b. REGISTRAR'S SIGNATURE <u>John J. Carver</u>	

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STATE OF MARYLAND

DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

83

2 4 6 8 8

1- FOR
STATE
REGISTRAR

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) John C. Metz			2a. DATE OF DEATH MONTH 9 DAY 19 YEAR 83			2b. HOUR 2:30 p.m.			
3. SEX Male		4. RACE Caucasian		5. DATE OF BIRTH MONTH 7 DAY 3 YEAR 08		6. AGE (IN YEARS LAST BIRTHDAY) 75 YRS.		7. IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Md.		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH HOWARD MD.			
10. CITY OR TOWN OF DEATH Cocksville		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 13905 Rt. 144				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) BANKER		12b. KIND OF BUSINESS OR INDUSTRY Finance	
13a. STATE Md.		13b. COUNTY Howard		13c. CITY OR TOWN Cocksville		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS 13905 Rt. 144 21030	
14. FATHER'S NAME FIRST Charles MIDDLE Edward LAST Metz				15. MOTHER'S MAIDEN NAME FIRST Unk MIDDLE Unk LAST Unk					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No				16b. SOCIAL SECURITY NO. 217 14 4129		17. INFORMANT ADDRESS John Clark, Attorney Marriottsville, Md.			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY 1991 IMMEDIATE CAUSE (a) Respiratory Failure DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Diffuse Melanotic Cancer DUE TO, OR AS A CONSEQUENCE OF (c) _____ APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH _____									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a). Terminal Cancer									
19a. DATE OF OPERATION _____			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED _____			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. _____ 19 _____		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) _____				
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) _____		21f. LOCATION STREET _____ CITY OR TOWN _____ COUNTY _____ STATE _____				
22a. I certify that (I) (this hospital) attended the deceased from 9-10 , 19 83 , to 9-19 , 19 83 , that (I) (we) lost saw the deceased alive on 9-19-83 , 19 83 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE Lawrence A. Silverburg DEGREE _____ ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>						22c. DATE SIGNED 9-20-83			
22d. PHYSICIAN'S NAME (TYPE OR PRINT) DR. LAWRENCE I. SILVERBURG						22e. ADDRESS Ellicott City, Md. 21043			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Cremation			23b. DATE 9-23-83		23c. NAME OF CEMETERY OR CREMATORY Security Process		23d. LOCATION CITY OR TOWN Catonsville COUNTY Md.		
24. FUNERAL DIRECTOR NAME Harry W Haight ADDRESS Sykesville, Md.				25a. DATE REC'D. BY REGISTRAR SEP 22 1983		25b. REGISTRAR'S SIGNATURE John J. Carver			

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the death certificate with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

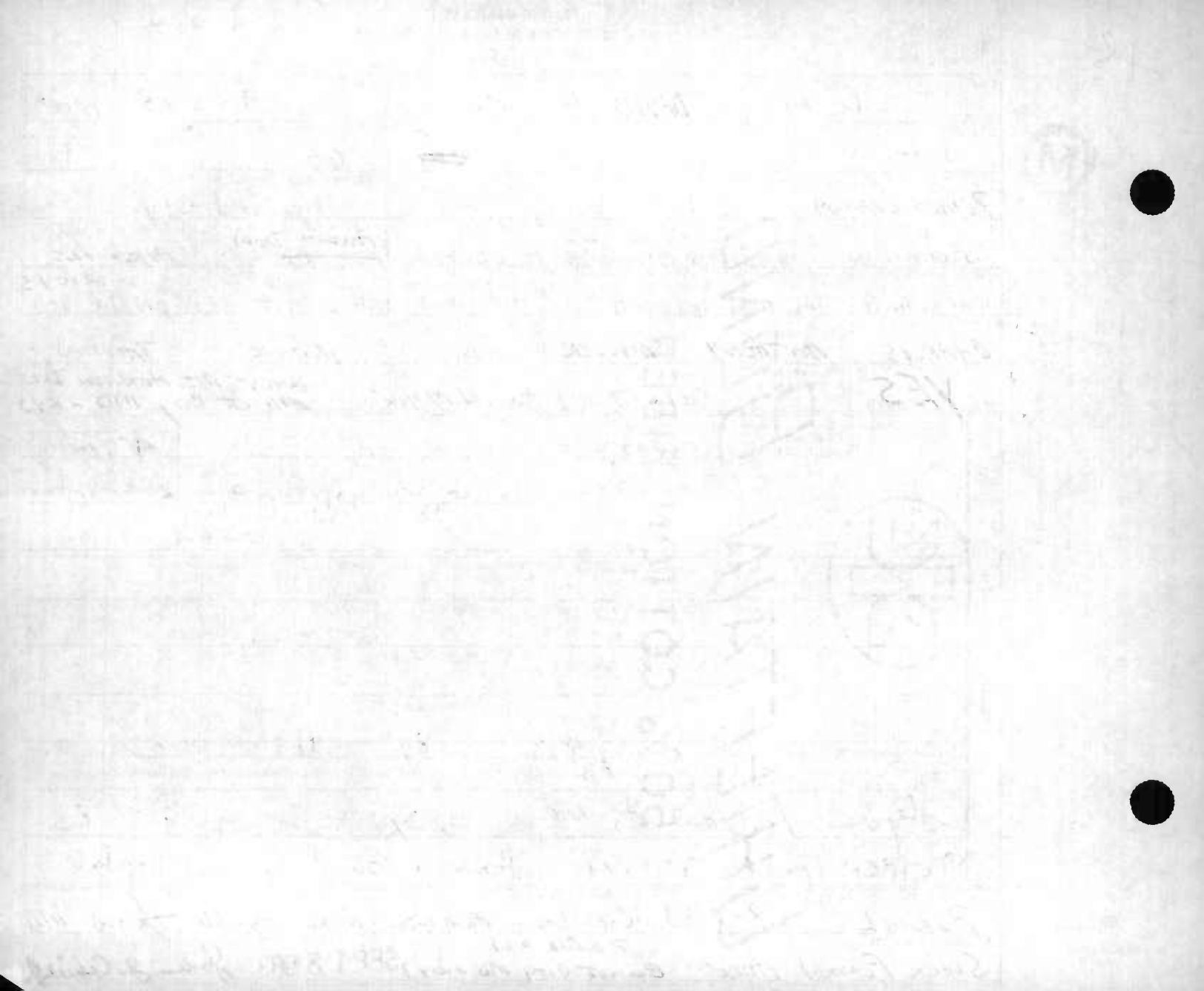
BP _____



STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. FOR STATE REGISTRAR		2a. DATE OF DEATH		2b. HOUR	
1. DECEASED NAME (TYPE OR PRINT)		MONTH DAY YEAR		MONTHS DAYS HOURS MIN.	
FIRST MIDDLE LAST		9 5 83		12:12 AM	
3. SEX		4. RACE		5. DATE OF BIRTH	
male		white		MONTH DAY YEAR	
6. AGE (IN YEARS LAST BIRTHDAY)		7. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	
65 YRS.		U.S.A.		WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
9a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		9. BALTIMORE CITY OR COUNTY OF DEATH		10. CITY OR TOWN OF DEATH	
PENNSYLVANIA		Howard Cty.		Columbia	
11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (FULL-TIME OR PART-TIME WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY	
Howard Cty. Gen Hospital		Retired		Retna Ins.	
13a. STATE		13b. COUNTY		13c. CITY OR TOWN	
MARYLAND		Howard		Ellicott City	
14. FATHER'S NAME		15. MOTHER'S MAIDEN NAME		13d. INSIDE CITY LIMITS?	
FIRST MIDDLE LAST		FIRST MIDDLE LAST		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
CHARLES ANTHONY MILLER		Rose Marie Thomas		13e. STREET ADDRESS	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>)		16b. SOCIAL SECURITY NO.		17. INFORMANT	
un/YES		201 017 238		Mary H. Miller	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)		19. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	
PART I. DEATH WAS CAUSED BY:		20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?	
IMMEDIATE CAUSE (a) 4254 Cardiopulmonary arrest		YES <input type="checkbox"/> NO <input type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>	
DUE TO, OR AS A CONSEQUENCE OF (b) Severe congestive cardiomyopathy and chronic obstructive lung disease		21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY	
DUE TO, OR AS A CONSEQUENCE OF (c)		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)		HOUR A.M. MONTH DAY YEAR	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)		21d. INJURY OCCURRED		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	
21f. LOCATION		21g. CITY OR TOWN		21h. COUNTY	
21i. STATE		21j. DATE SIGNED		21k. DEGREE	
21l. SIGNATURE		21m. DATE SIGNED		21n. DEGREE	
21o. SIGNATURE		21p. DATE SIGNED		21q. DEGREE	
21r. SIGNATURE		21s. DATE SIGNED		21t. DEGREE	
21u. SIGNATURE		21v. DATE SIGNED		21w. DEGREE	
21x. SIGNATURE		21y. DATE SIGNED		21z. DEGREE	
21aa. SIGNATURE		21ab. DATE SIGNED		21ac. DEGREE	
21ad. SIGNATURE		21ae. DATE SIGNED		21af. DEGREE	
21ag. SIGNATURE		21ah. DATE SIGNED		21ai. DEGREE	
21aj. SIGNATURE		21ak. DATE SIGNED		21al. DEGREE	
21am. SIGNATURE		21an. DATE SIGNED		21ao. DEGREE	
21ap. SIGNATURE		21aq. DATE SIGNED		21ar. DEGREE	
21as. SIGNATURE		21at. DATE SIGNED		21au. DEGREE	
21av. SIGNATURE		21aw. DATE SIGNED		21ax. DEGREE	
21ay. SIGNATURE		21az. DATE SIGNED		21ba. DEGREE	
21ba. SIGNATURE		21bb. DATE SIGNED		21bc. DEGREE	
21bd. SIGNATURE		21be. DATE SIGNED		21bf. DEGREE	
21bg. SIGNATURE		21bh. DATE SIGNED		21bi. DEGREE	
21bj. SIGNATURE		21bk. DATE SIGNED		21bl. DEGREE	
21bm. SIGNATURE		21bn. DATE SIGNED		21bo. DEGREE	
21bp. SIGNATURE		21bv. DATE SIGNED		21bw. DEGREE	
21bq. SIGNATURE		21bx. DATE SIGNED		21by. DEGREE	
21bz. SIGNATURE		21bz. DATE SIGNED		21bz. DEGREE	
21ca. SIGNATURE		21ca. DATE SIGNED		21ca. DEGREE	
21cb. SIGNATURE		21cb. DATE SIGNED		21cb. DEGREE	
21cc. SIGNATURE		21cc. DATE SIGNED		21cc. DEGREE	
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21ck. SIGNATURE		21ck. DATE SIGNED		21ck. DEGREE	
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21co. SIGNATURE		21co. DATE SIGNED		21co. DEGREE	
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21go. SIGNATURE		21go. DATE SIGNED		21go. DEGREE	
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21gx. SIGNATURE		21gx. DATE SIGNED		21gx. DEGREE	
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21ha. SIGNATURE		21ha. DATE SIGNED		21ha. DEGREE	
21hb. SIGNATURE		21hb. DATE SIGNED		21hb. DEGREE	
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21hq. SIGNATURE		21hq. DATE SIGNED		21hq. DEGREE	
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21hs. SIGNATURE		21hs. DATE SIGNED		21hs. DEGREE	
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21hu. SIGNATURE		21hu. DATE SIGNED		21hu. DEGREE	
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21hw. SIGNATURE		21hw. DATE SIGNED		21hw. DEGREE	
21hx. SIGNATURE		21hx. DATE SIGNED		21hx. DEGREE	
21hy. SIGNATURE		21hy. DATE SIGNED		21hy. DEGREE	
21hz. SIGNATURE		21hz. DATE SIGNED		21hz. DEGREE	
21ia. SIGNATURE		21ia. DATE SIGNED		21ia. DEGREE	
21ib. SIGNATURE		21ib. DATE SIGNED		21ib. DEGREE	
21ic. SIGNATURE		21ic. DATE SIGNED		21ic. DEGREE	
21id. SIGNATURE		21id. DATE SIGNED		21id. DEGREE	
21ie. SIGNATURE		21ie. DATE SIGNED		21ie. DEGREE	
21if. SIGNATURE		21if. DATE SIGNED		21if. DEGREE	
21ig. SIGNATURE		21ig. DATE SIGNED		21ig. DEGREE	
21ih. SIGNATURE		21ih. DATE SIGNED		21ih. DEGREE	
21ii. SIGNATURE		21ii. DATE SIGNED		21ii. DEGREE	
21ij. SIGNATURE		21ij. DATE SIGNED		21ij. DEGREE	
21ik. SIGNATURE		21ik. DATE SIGNED		21ik. DEGREE	
21il. SIGNATURE		21il. DATE SIGNED		21il. DEGREE	
21im. SIGNATURE		21im. DATE SIGNED		21im. DEGREE	
21in. SIGNATURE		21in. DATE SIGNED		21in. DEGREE	
21io. SIGNATURE		21io. DATE SIGNED		21io. DEGREE	
21ip. SIGNATURE		21ip. DATE SIGNED		21ip. DEGREE	
21iq. SIGNATURE		21iq. DATE SIGNED		21iq. DEGREE	
21ir. SIGNATURE		21ir. DATE SIGNED		21ir. DEGREE	
21is. SIGNATURE		21is. DATE SIGNED		21is. DEGREE	
21it. SIGNATURE		21it. DATE SIGNED		21it. DEGREE	
21iu. SIGNATURE		21iu. DATE SIGNED		21iu. DEGREE	



DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

24690
2b HOUR 7:50 PM1. FOR
STATE
REGISTRAR1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST
Nellie M. Miller2a. DATE OF DEATH MONTH DAY YEAR
9-30-833 SEX
Female4 RACE
White5. DATE OF BIRTH MONTH DAY YEAR
July 3, 19076 AGE (IN YEARS LAST BIRTHDAY) MONTHS DAYS HOURS MIN.
76 YRS.7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
Howard Cty, Md.7b. CITIZEN OF WHAT COUNTRY?
U. S. A.8. MARRIED ☐ NEVER MARRIED ☐
WIDOWED ☒ DIVORCED ☐9 BALTIMORE CITY OR COUNTY OF DEATH
Howard County, MD.10 CITY OR TOWN OF DEATH
Sykesville11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
Sykesville Elder Care Center12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)
Housewife12b. KIND OF BUSINESS OR INDUSTRY
----13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)
13b. STATE
Md.13c. CITY OR TOWN
Catonsville13d. INSIDE CITY LIMITS? YES ☐ NO ☒
13e. STREET ADDRESS
2 August Avenue -21228.14 FATHER'S NAME FIRST MIDDLE LAST
Lee Wiegandt15 MOTHER'S MAIDEN NAME FIRST MIDDLE LAST
Mattie Bennett16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)
No16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES)
-----17. INFORMANT ADDRESS
215 Rockridge Rd. - Woodlawn,
D-Mrs. Margaret E. Boyle-Md. 21207.18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))
PART I. DEATH WAS CAUSED BY:IMMEDIATE CAUSE (a) possible pneumonia
5990

DUE TO, OR AS A CONSEQUENCE OF

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

(b) infected decubiti, both hips

DUE TO, OR AS A CONSEQUENCE OF

(c) chronic urinary tract infection, dehydration

APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)

MEDICAL CERTIFICATION

19a. DATE OF OPERATION

19b. CONDITION FOR WHICH OPERATION WAS PERFORMED

20a. AUTOPSY?

YES ☐ NO ☒

20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?

YES ☐ NO ☐21a. ACCIDENT WAS UNDERLYING ☐
OR CONTRIBUTING ☐ CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER)21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR
P.M. 19

21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)

21d. INJURY OCCURRED WHILE ☐ NOT WHILE ☐
AT WORK AT WORK

21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)

21f. LOCATION STREET CITY OR TOWN COUNTY STATE

22a. I certify that (I) (this hospital) attended the deceased from 8-17, 19 83, to 9-30-19 83, that (I) (we) last saw the deceased alive on 9-30 19 83, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE
Hyung Chun Kim, M.D.

DEGREE

ATTENDING PHYSICIAN ☒ MEDICAL DIRECTOR ☐ STAFF PHYSICIAN ☐22c. DATE SIGNED
9-30-198322d. PHYSICIAN'S NAME (TYPE OR PRINT)
Hyung C. Kim22e. ADDRESS
2413 Walden Way
Mannettsville, Md 2110423a. BURIAL, CREMATION, REMOVAL (SPECIFY)
Burial23b. DATE
10/3/8323c. NAME OF CEMETERY OR CREMATORY
Meadowridge Mem. Park23d. LOCATION CITY OR TOWN COUNTY STATE
Howard County, Md.24. FUNERAL DIRECTOR, NAME ADDRESS
Sterling Funeral Estate, P.A.
736 Edmondson Ave. - Catonsville, Md. 2122825a. DATE REC'D. BY REGISTRAR
OCT 3 - 198325b. REGISTRAR'S SIGNATURE
John J. Conner

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.



DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

2 4 6 9 1

REG. NO.

FOR
1- STATE
REGISTRAR

1 DECEASED NAME (TYPE OR PRINT) JOHN JOSEPH MOELLER			2a DATE OF DEATH MONTH DAY YEAR 9 29 83			2b HOUR 5:19 PM			
3 SEX MALE		4 RACE WHITE		5 DATE OF BIRTH MONTH DAY YEAR 09 10 96		6 AGE (IN YEARS LAST BIRTHDAY) 87 YRS		IF UNDER 1 YEAR MONTHS DAYS HOURS MIN	
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY) MARYLAND		7b CITIZEN OF WHAT COUNTRY? U.S.A.		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH Howard Co MD.			
10 CITY OR TOWN OF DEATH Columbia		11 NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY GIVE STREET ADDRESS) Howard Co. Gen. Hospital				12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) ASST. MANAGER		12b KIND OF BUSINESS OR INDUSTRY STEAMSHIP	
13a STATE NEW JERSEY		13b COUNTY HUDSON		13c CITY OR TOWN JERSEY CITY		13d INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		13e STREET ADDRESS 39 DUNCAN	
14 FATHER'S NAME FIRST MIDDLE LAST JOHN MOELLER				15 MOTHER'S MAIDEN NAME FIRST MIDDLE LAST MARGARET C. O'BOYLE				ADDRESS ELLICOTT CITY, MD.	
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) YES		16b SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) WW I		17 INFORMANT ADDRESS EDWARD L. MOELLER 8533 MARYBETH WAY 21043					
18 CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c) PART 1: DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Respiratory/Cardiac arrest 4100 DUE TO, OR AS A CONSEQUENCE OF (b) Cardiogenic Shock Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (c) possible myocardial infarction, possible sepsis APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH Seconds ~3 days ~2-3 days									
PART 2: OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: Renal failure, possible mesenteric ischemia									
19a DATE OF OPERATION		19b CONDITION FOR WHICH OPERATION WAS PERFORMED				20a AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
21d INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f LOCATION STREET CITY OR TOWN COUNTY STATE					
22a I certify that (I) (this hospital) attended the deceased from 9/29 , 19 83 , to 9/29 , 19 83 , that (I) (we) last saw the deceased alive on 9/29 , 19 83 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.									
22b SIGNATURE Stephen A. Valenti MD				DEGREE CONSULTING CARDIOLOGIST ATTENDING MEDICAL STAFF PHYSICIAN <input type="checkbox"/> DIRECTOR <input type="checkbox"/> PHYSICIAN <input type="checkbox"/>				22c DATE SIGNED 9/29/83	
22d PHYSICIAN'S NAME (TYPE OR PRINT) STEPHEN A. VALENTI MD				22e ADDRESS Howard County General Hospital					
23a BURIAL, CREMATION, REMOVAL (SPECIFY) REMOVAL/BURIAL		23b DATE 10-04-83		23c NAME OF CEMETERY OR CREMATORY HOLY NAME CEMETERY		23d LOCATION CITY OR TOWN COUNTY STATE JERSEY CITY HUDSON N.J.			
24 FUNERAL DIRECTOR NAME HUBBARD FUNERAL HOME, INC. 4107 WILKENS AVE.				BALTO., MD. 21229 ADDRESS		25a DATE REC'D. BY REGISTRAR Oct 3 1983			

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. It may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed with the local health department with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked on item 18, when any injury, or other traumatic event, the medical examiner must be notified to be notified to be notified.

31A

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH									
1 - FOR STATE REGISTRAR			REG. NO.						
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Carolyn Ford Mulhearn						2a. DATE OF DEATH MONTH DAY YEAR Sept. 10, 1983		2b. HOUR 2 P.M.	
3 SEX Female		4 RACE White		5 DATE OF BIRTH MONTH DAY YEAR 3-6-1927		6 AGE (IN YEARS LAST BIRTHDAY) YRS MONTHS DAYS 56		7. UNDER 1 YEAR IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Galloway W. Va.		7b. CITIZEN OF WHAT COUNTRY? U. S. A.		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH Howard Co. Md.			
10 CITY OR TOWN OF DEATH Columbia,		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 6601 Quiet Hours Drive Apt. 2-T				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Restaurant Manager		12b. KIND OF BUSINESS OR INDUSTRY Dept. Store	
13a. STATE Md.						13b. COUNTY Howard		13c. CITY OR TOWN Columbia	
14. FATHER'S NAME FIRST MIDDLE LAST John Hanley, Jr.						15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Maude Bunner			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) no		16b. SOCIAL SECURITY NO. 234-32-4727		17. INFORMANT ADDRESS Mr. Leo G. Mulhearn 6601 Quiet Hours Drive Apt. 2-T Columbia, Md. 20794					
18. CAUSE OF DEATH (Enter only one cause per line (a), (b), and (c). PART 1. DEATH WAS CAUSED BY 1749 IMMEDIATE CAUSE (a) Respiratory arrest DUE TO, OR AS A CONSEQUENCE OF (b) Cerebral metastases DUE TO, OR AS A CONSEQUENCE OF (c) metastatic breast carcinoma PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR 9 P.M. 19 83		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from 9/10 19 83 , to 9/10 19 83 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE James M. Jones #MO				DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>				22c. DATE SIGNED 9/12/83	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) JAMES M. JONES #MO				22e. ADDRESS UNIV. OF MD. CANCER CENTER					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 9-13-83		23c. NAME OF CEMETERY OR CREMATORY Milton Cem. 3 Circle Ave.		23d. LOCATION CITY OR TOWN COUNTY STATE Milton Mass.			
24. FUNERAL DIRECTOR G. Truman Schwab 5151 Balto. National Pike Baltimore Md. 21229						25a. DATE REC'D. BY REGISTRAR SEP 19 1983		25b. REGISTRAR'S SIGNATURE [Signature]	





TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE											
CHARLES MILTON NEGLEY CERTIFICATE OF DEATH											
REG. NO.											
1. FOR STATE REGISTRAR Charles M. NEGLEY					2a. DATE OF DEATH MONTH DAY YEAR 9 14 83					2b. HOUR 2:40 PM	
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Charles M. NEGLEY		3. SEX Male		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR 03 02 26		6. AGE (IN YEARS LAST BIRTHDAY) 57 YRS		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Howard County MD.					
10. CITY OR TOWN OF DEATH Columbia		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Howard County General Hospital				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Foreman		12b. KIND OF BUSINESS OR INDUSTRY Telephone Co.			
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)					13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					13e. STREET ADDRESS Apt. 118 21044 10850 Green Mountain Circle	
13a. STATE Maryland		13b. COUNTY Howard		13c. CITY OR TOWN Columbia							
14. FATHER'S NAME FIRST MIDDLE LAST Charles M. Negley					15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Marie Samsal						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) Yes		16b. SOCIAL SECURITY NO. WW 2		17. INFORMANT 13400 Folly Quarter Road Joseph Negley, Ellicott City, Md, 21043							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Congestive Heart Failure 4100 DUE TO, OR AS A CONSEQUENCE OF (b) Acute Myocardial Infarction DUE TO, OR AS A CONSEQUENCE OF (c) APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH											
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)							
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE							
22a. I certify that (I) (this hospital) attended the deceased from 9/13/83, 19, to 9/14/83, 19, that (I) (we) last saw the deceased alive on 9/14/83, 19, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE [Signature]		DEGREE MD		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 9/14/83					
22d. PHYSICIAN'S NAME (TYPE OR PRINT) RUFAEL		22e. ADDRESS 10840 LITTLE PATUXENT PKY. CO, MD 21044									
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 9/17/83		23c. NAME OF CEMETERY OR CREMATORY New Cathedral Cemetery Baltimore Md.		23d. LOCATION CITY OR TOWN COUNTY STATE					
24. FUNERAL HOME (NAME) L. & Russell C. Witzke		24b. ADDRESS 1630 Edmondson Avenue, Catonsville, Md. 21228		25a. DATE REC'D. BY REGISTRAR SEP 16 1983		25b. REGISTRAR'S SIGNATURE [Signature]					



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STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

2 4 6 9 4

1. FOR STATE REGISTRAR		1. DECEASED NAME (TYPE OR PRINT)		FIRST	MIDDLE	LAST	2a. DATE OF DEATH	MONTH	DAY	YEAR	2b. HOUR
		Ruth				Rhea	9-6-83				2:00 PM
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (IN YEARS LAST BIRTHDAY)		IF UNDER 1 YEAR		IF UNDER 24 HRS	
FEMALE		Black		2/15/1900		83		MONTHS		DAYS	
7. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH					
WASH., D.C.		U.S.A.				HOWARD				MD	
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY					
COLUMBIA		HOWARD COUNTY GEN. HOSPT.		FED. GOV-RET.							
13a. STATE		13b. CITY OR TOWN		13c. INSIDE CITY LIMITS?		13d. STREET ADDRESS					
MD		WASH., D.C.		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		529 25th. Pl., N. E.					
14. FATHER'S NAME		15. MOTHER'S MAIDEN NAME		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO.		17. INFORMANT			
LEROY HARKINS		ROSA HAWKINS		NO		577-84-3679		5255 Runningbrook Rd. Columbia, Md.			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY		IMMEDIATE CAUSE (a)		4100		Cardiogenic Shock		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last		DUE TO, OR AS A CONSEQUENCE OF		(b)		Probable Acute H.I.					
		DUE TO, OR AS A CONSEQUENCE OF		(c)		ASCVD, HICVD.					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)		Hypertension; Anemia.		Hx of CVA in Past							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?					
				YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)							
		P.M. 19									
21d. INJURY OCCURRED		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION		CITY OR TOWN		COUNTY		STATE	
WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK				STREET							
22a. I certify that (I) (this hospital) attended the deceased from		4-5-19-83		to		9-6-19-83		that (I) (we) last			
saw the deceased alive on		9-6-19-83		and that in (my) (our) opinion death occurred on the date and hour and from the causes stated							
22b. SIGNATURE		DEGREE		22c. DATE SIGNED							
A. Divakaruni		MD		9-6-83							
22d. PHYSICIAN'S NAME (TYPE OR PRINT)		22e. ADDRESS		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>							
A. DIVAKARUNI		10806 Hickory Ridge Rd. Columbia MD 21046									
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION		CITY OR TOWN		COUNTY STATE	
BURIAL		9/13/83		MARYLAND NATIONAL		LAUREL, MARYLAND					
24. FUNERAL DIRECTOR		25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE							
MORROW & WOODFORD, INC. 1622 11th. St., NW Wash., D.C. 20001		SEP 15 1983		John J. Canfield							

Miss G. J. 87.01.938

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1 - STATE
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) Margaret Shirer			2a. DATE OF DEATH MONTH DAY YEAR 9 25 83			2b. HOUR 8:35 AM					
3. SEX F		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR 10 26 96		6. AGE (IN YEARS LAST BIRTHDAY) 86 YRS.		7. IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Ireland		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Howard County MD.					
10. CITY OR TOWN OF DEATH Columbia		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Lorien Nursing Center				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) MISSIONARY		12b. KIND OF BUSINESS OR INDUSTRY INTERPRETER			
13a. STATE MD			13b. COUNTY Howard		13c. CITY OR TOWN Columbia		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS 21044 10637 Faulkner Ridge		
14. FATHER'S NAME FIRST MIDDLE LAST ALEXANDER			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST ISABELLA BURNS			16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) NO -				16b. SOCIAL SECURITY NO. 179-32-0506	
17. INFORMANT ADDRESS Marguerite Bridge 6170 Lowyers Hill Rd Elkridge, Md 21227											

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART 1. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a)

4360
Conditions, if any, which
gave rise to immediate
cause (a), stating the
underlying cause last.

DUE TO, OR AS A CONSEQUENCE OF

(b)

DUE TO, OR AS A CONSEQUENCE OF

(c)

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a)

19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18: PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from 11-3, 19 78, to 9-25, 19 83, that (I) (we) last saw the deceased alive on 9-21-83, 19, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE Richard W. Smith M.D.		DEGREE		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 9-25-83	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Richard W. Smith M.D.		22e. ADDRESS 5999 Harpers Farm Rd Columbia Md. 21061					

23a. BURIAL, CREMATION, REMOVAL Burial		23b. DATE 9-28-83		23c. NAME OF CEMETERY OR CREMATORY St. Johns Cem		23d. LOCATION CITY OR TOWN COUNTY STATE Cecil City Howard MD	
24. FUNERAL DIRECTOR NAME SLACK FUNERAL HOME		ADDRESS P.O. Box 268 CECIL CITY MD 21030		25a. DATE REC'D. BY REGISTRAR SEP 29 1983		25b. REGISTRAR'S SIGNATURE John J. Connel	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the registrars, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

Handwritten text, mostly illegible due to fading and bleed-through. Some words like "The", "and", "of" are visible.

2029 OCT 1



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

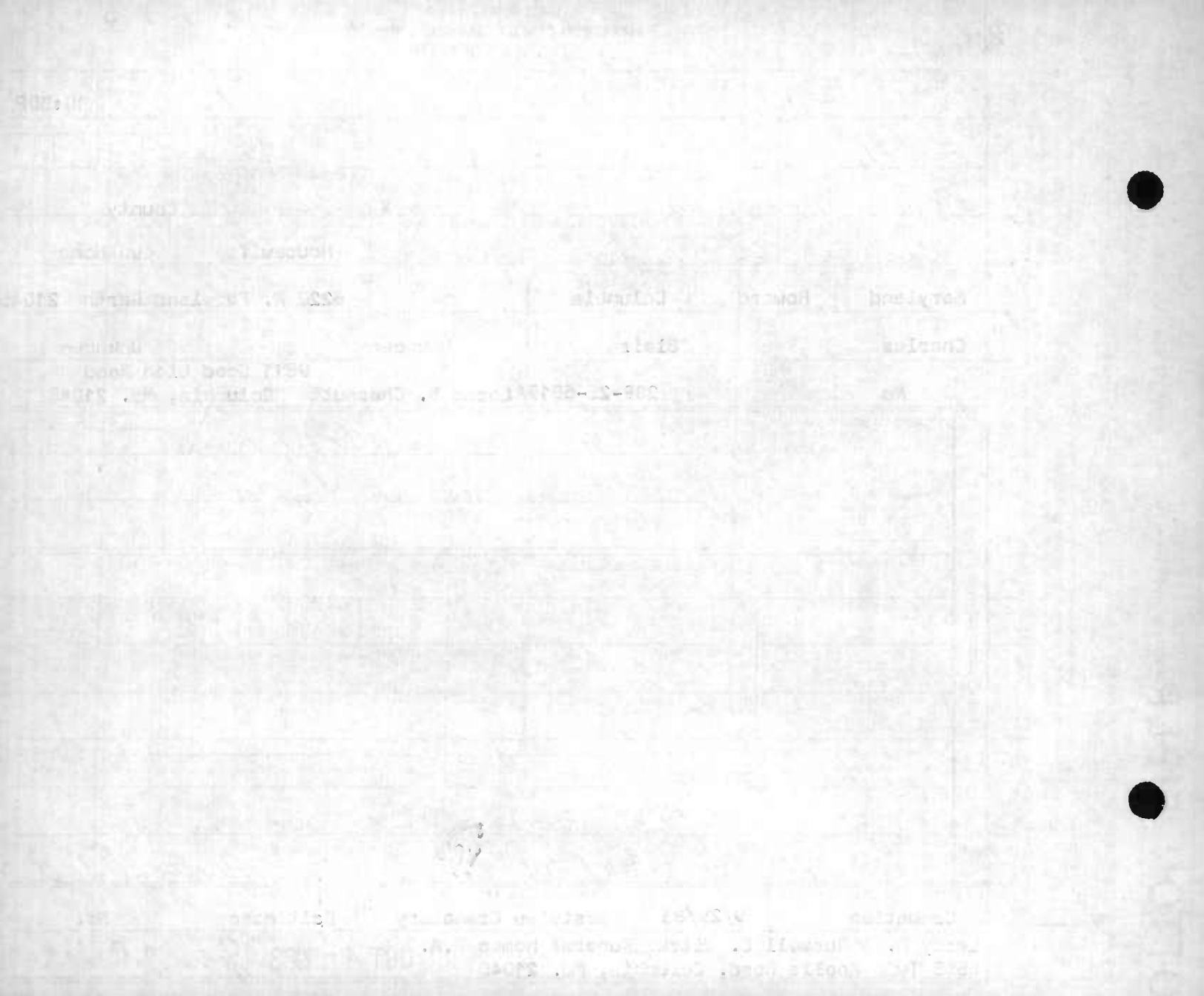
FOR
1. STATE
REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) <i>Edna B. Stevenson</i>			2a. DATE OF DEATH MONTH <i>9</i> DAY <i>28</i> YEAR <i>83</i>			2b. HOUR <i>10:30 P.M.</i>									
3. SEX <i>Female</i>		4. RACE <i>White</i>		5. DATE OF BIRTH MONTH <i>9</i> DAY <i>3</i> YEAR <i>09</i>		6. AGE (IN YEARS LAST BIRTHDAY) <i>74</i> YRS.		IF UNDER 1 YEAR MONTHS <i></i> DAYS <i></i>		IF UNDER 24 HRS. HOURS <i></i> MIN <i></i>					
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <i>Illinois</i>		7b. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <i>Howard County</i> MD									
10. CITY OR TOWN OF DEATH <i>Columbia</i>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <i>6220 M. Foreland Garth</i>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <i>Housewife</i>			12b. KIND OF BUSINESS OR INDUSTRY <i>Own Home</i>						
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)															
13a. STATE <i>Maryland</i>			13b. COUNTY <i>Howard</i>			13c. CITY OR TOWN <i>Columbia</i>			13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			13e. STREET ADDRESS <i>6220 M. Foreland Garth 21045</i>			
14. FATHER'S NAME FIRST <i>Charles</i> MIDDLE <i></i> LAST <i>Blair</i>						15. MOTHER'S MAIDEN NAME FIRST <i>Unknown</i> MIDDLE <i></i> LAST <i>Unknown</i>									
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <i>No</i>				16b. SOCIAL SECURITY NO. <i>289-28-6919</i>				17. INFORMANT <i>9519 DRESS Good Lion Road</i> <i>Lorna S. Chesnutt Columbia, Md. 21045</i>							
18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>4140 Cardiorespiratory arrest</i> DUE TO, OR AS A CONSEQUENCE OF (b) <i>Coronary heart disease</i> DUE TO, OR AS A CONSEQUENCE OF (c) <i></i> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last: <i></i>												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>minutes</i>			
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <i></i>															
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <i>P.M. 19</i>				21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)							
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)				21f. LOCATION STREET CITY OR TOWN COUNTY STATE							
22a. I certify that (1) (this hospital) attended the deceased from <i>9/13/83</i> to <i>9/13/83</i> , that (1) (we) lost saw the deceased alive on <i>9/13/83</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above (1) (we) (did) (did not) know the body after death.															
22b. SIGNATURE <i>H. G. Stahl, MD</i> DEGREE <i>MD</i>												22c. DATE SIGNED			
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <i>H. G. Stahl, MD</i>												22e. ADDRESS <i>Columbia Medical Plaza</i>			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <i>Cremation</i>				23b. DATE <i>9/29/83</i>		23c. NAME OF CEMETERY OR CREMATORY <i>Westview Crematory</i>				23d. LOCATION CITY OR TOWN <i>Baltimore</i> COUNTY <i></i> STATE <i>Md.</i>					
24. FUNERAL DIRECTOR NAME <i>Leroy M. & Russell C. Witzke Funeral Homes P.A.</i> ADDRESS <i>5555 Twin Knolls Road, Columbia, Md. 21045</i>												25a. DATE REC'D. BY REGISTRAR <i>OCT 4 - 1983</i>		25b. REGISTRAR'S SIGNATURE <i>John J. Carver</i>	

BP

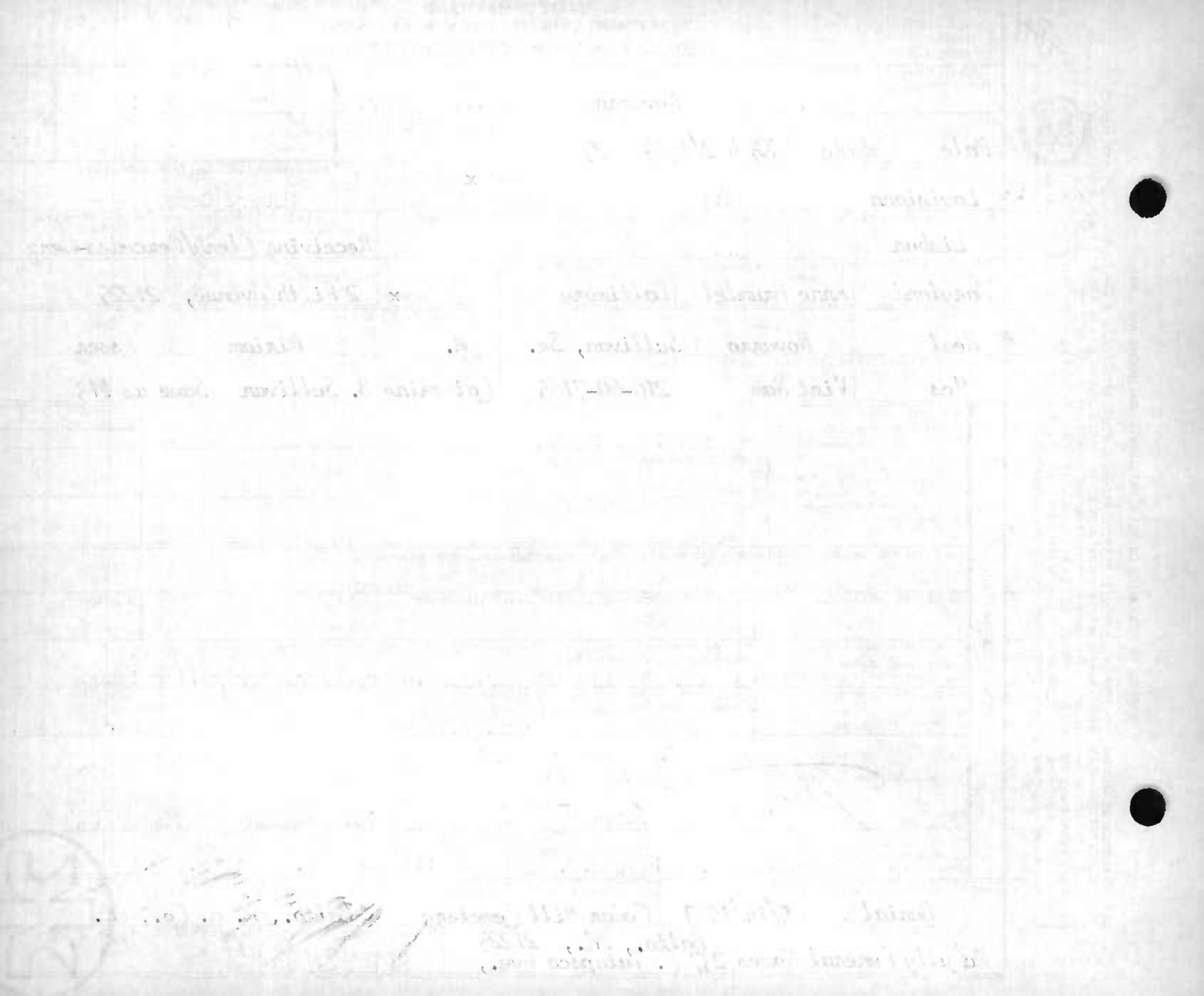


TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF, MEDICAL EXAMINER ALONG WITH FORM FM-3. RETAIN PAGE 3 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 24 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

BP

DHMH - 17
(VR A15 ME (5))
20M 4-B/2

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH										REG. NO.	
1. DECEASED NAME (TYPE OR PRINT) Neal Novarro Sullivan, Jr.						2a. DATE KNOWN OF DEATH ESTIMATED 9 10 1983		2b. HOUR 4:30			
3. SEX Male	4. RACE White	5. DATE OF BIRTH MONTH DAY YEAR XX 4/2/1954	6. AGE (IN YEARS) LAST BIRTHDAY 29 YRS.	IF UNDER 1 YR. MONTHS DAYS	IF UNDER 24 HRS. HOURS MIN	2c. DATE PRONOUNCED DEAD 9 10 1983		2d. HOUR 4:30			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Louisiana		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Howard County, MD.					
10. CITY OR TOWN OF DEATH Lisbon		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Rt. 70 & 94				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Receiving Clerk/Mercedes-Benz		12b. KIND OF BUSINESS OR INDUSTRY			
13a. STATE Maryland		13b. CITY OR TOWN Anne Arundel		13c. CITY OR TOWN Baltimore		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS 2 Fifth Avenue, 21225			
14. FATHER'S NAME FIRST MIDDLE LAST Neal Novarro Sullivan, Sr.			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST A. Miriam Essen			16. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) (IF YES, GIVE WAR OR DATES) Yes Viet Nam					
16a. SOCIAL SECURITY NO. 216-60-7185			17. INFORMANT Catherine B. Sullivan Same as #13								
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Multiple injuries 8/20 Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause lost. (b) _____ (c) _____ DUE TO, OR AS A CONSEQUENCE OF									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).											
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?					20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
21a. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR 3 xxx 9 10 19 83		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) Driver in truck/tractor/trailer impact						
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) road		21f. LOCATION STREET CITY OR TOWN COUNTY STATE Rts. 70 & 94 Howard Md.						
22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> . Inspection <input type="checkbox"/> . Inquiry <input type="checkbox"/> . and in my opinion death resulted from: <input type="checkbox"/> Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> .											
ACTUAL SIGNATURE Thomas D. Smith			TITLE (SPECIFY) M.D. Deputy Chief			DATE SIGNED 9/10/83					
EXAMINER'S NAME (TYPE OR PRINT) Thomas D. Smith, M.D.			ADDRESS 111 Penn St. Balto., MD.								
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 9/14/1983		23c. NAME OF CEMETERY OR CREMATORY Cedar Hill Cemetery			23d. LOCATION CITY OR TOWN COUNTY STATE Balto., A. A. Co., Md.				
24. FUNERAL DIRECTOR NAME McGully Funeral Homes			ADDRESS Balto., Md., 21225 237 E. Patapsco Ave.,			25. DATE REC'D. BY REGISTRAR SEP 13 1983		25b. REGISTRAR'S SIGNATURE John J. Smith			



STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1- FOR
STATE
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) Mary JANE Waddell			2a. DATE OF DEATH MONTH DAY YEAR September 11 83			2b. HOUR 2:30 PM				
3. SEX FEMALE		4. RACE WHITE		5. DATE OF BIRTH MONTH DAY YEAR July 5, 1922			6. AGE (IN YEARS LAST BIRTHDAY) 61			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Howard Co. MD.				
10. CITY OR TOWN OF DEATH Columbia		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Howard Co. General Hosp.			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Cashier		12b. KIND OF BUSINESS OR INDUSTRY Dept. Store			
13a. STATE Maryland			13b. COUNTY Howard		13c. CITY OR TOWN Columbia		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
13e. STREET ADDRESS 10134 Cape Ann Dr. 21046										
14. FATHER'S NAME FIRST MIDDLE LAST George Nelson			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Julia Shewbridge							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No.			16b. SOCIAL SECURITY NO. 186-14-7425			17. INFORMANT ADDRESS Cheryl D. Dercola Columbia, Md. 21046				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY. 1840 IMMEDIATE CAUSE (a) Carcinoma of Colon DUE TO, OR AS A CONSEQUENCE OF (b) Vagina Extroy DUE TO, OR AS A CONSEQUENCE OF (c) dingto rectum & pelvic wall								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)										
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR 6/14/83			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18. PART 1 OR PART 2)				
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE				
22a. I certify that (I) (this hospital) attended the deceased from 6/14/83 to 9/11/83 , that (I) (we) last saw the deceased alive on 9/11/83 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) did not view the body after death.										
22b. SIGNATURE Moges Gebremariam			DEGREE MD ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>				22c. DATE SIGNED 9/11/83			
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Moges Gebremariam			22e. ADDRESS							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial			23b. DATE 9/15/83		23c. NAME OF CEMETERY OR CREMATORY Cedar Hill Cem.			23d. LOCATION CITY OR TOWN COUNTY STATE Suitland, P.G. Co. Md.		
24. FUNERAL DIRECTOR FLUCK FUNERAL HOME, INC. ADDRESS 7601 Sandy Spring Rd. Laurel, Md. 20707						25a. DATE REC'D. BY REGISTRAR SEP 13 1983		25b. REGISTRAR'S SIGNATURE John J. L...		

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

24. FUNERAL DIRECTOR

FLUCK FUNERAL HOME, INC. ADDRESS

7601 Sandy Spring Rd. Laurel, Md. 20707

25a. DATE REC'D. BY REGISTRAR

SEP 13 1983

25b. REGISTRAR'S SIGNATURE

John J. L...



REPT. NO. 100-200

State of New York
County of ...
In SENATE
January 12, 1900

Report of the
Commissioners of the
Department of
Education
for the year
ending June 30, 1899

Printed by the
State Printer
Albany, N. Y.
1900

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

24699

30
1. FOR
STATE
REGISTRAR

REG. NO.

1 DECEASED NAME (TYPE OR PRINT) MADELEINE B. WHITE		2a DATE OF DEATH MONTH DAY YEAR 9-13-83		2b HOUR 8⁵⁵ P.M.	
3 SEX F	4 RACE W.	5 DATE OF BIRTH MONTH DAY YEAR 08 23 1901		6 AGE (IN YEARS LAST BIRTHDAY) 82 YRS	
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY) Canada	7b CITIZEN OF WHAT COUNTRY? U.S.A.	8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH Howard MD.	
10 CITY OR TOWN OF DEATH Columbia	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Howard County Gen.		12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Retired		12b KIND OF BUSINESS OR INDUSTRY
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a STATE MD.		13b COUNTY Howard	13c CITY OR TOWN Columbia	13d INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>	
14 FATHER'S NAME FIRST MIDDLE LAST late Harry Francis Barthelmes		15 MOTHER'S MAIDEN NAME FIRST MIDDLE LAST late Clara Murphy			
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b SOCIAL SECURITY NO. 215 36 4999		17 INFORMANT ADDRESS M. Engle Ho. Cty. Gen Hosp ER	
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: 4409 IMMEDIATE CAUSE (a) Ruptured abdominal aortic aneurysm DUE TO, OR AS A CONSEQUENCE OF (b) ARTERIOSCLEROSIS DUE TO, OR AS A CONSEQUENCE OF (c) _____ CONDITIONS, if any, which gave rise to immediate cause (a), stating the underlying cause last					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 10 hrs
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a). NONE					
19a DATE OF OPERATION		19b CONDITION FOR WHICH OPERATION WAS PERFORMED		20a AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
21d INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f LOCATION STREET CITY OR TOWN COUNTY STATE	
22a I certify that (I) (this hospital) attended the deceased from 9-70 to 9-13 19 83 , that (I) view lost saw the deceased alive on 9-13 19 83 , and that in (my) four opinion death occurred on the date and hour and from the causes stated above, (I) view (did) not view the body after death.					
22b SIGNATURE Laurence R. Gallagher, M.D.		DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c DATE SIGNED 9-13-83	
22d PHYSICIAN'S NAME (TYPE OR PRINT) LAURENCE R. GALLAGHER, M.D.		22e ADDRESS ST AGNES MEDICAL CENTER WILKENS + PINEHILLS, BALTO, MD. 21229			
23a BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b DATE Sept 17'83		23c NAME OF CEMETERY OR CREMATORY Fort Lincoln	
23d LOCATION CITY OR TOWN COUNTY STATE Brentwood, Prince Geo, Md.		25a DATE REC'D. BY REGISTRAR SEP 16 1983			
24 FUNERAL DIRECTOR NAME Harry H Witzke 4112 Columbia RD Ellicott City		25b REGISTRAR'S SIGNATURE John J. [Signature]			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP _____

Brantwood, Prince Geo. N.S.

Harry H. Wicks 4112 Columbia Rd. Kilauea City
Sept 17 '82
Fort Lincoln

Bullard

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 22 hours with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified and allowed to examine the body.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH				24700			
1. FOR STATE REGISTRAR				REG. NO.			
1. DECEASED NAME (TYPE OR PRINT) <u>Richard F. Willey</u>				2a. DATE OF DEATH MONTH <u>9</u> DAY <u>27</u> YEAR <u>83</u>			
3. SEX <u>Male</u>				2b. HOUR <u>11:15 PM</u>			
4. RACE <u>CAUCASIAN</u>		5. DATE OF BIRTH MONTH <u>8</u> DAY <u>14</u> YEAR <u>27</u>		6. AGE (IN YEARS LAST BIRTHDAY) <u>56</u> YRS.		IF UNDER 1 YEAR MONTHS <u></u> DAYS <u></u>	
7. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <u>MD</u>		7b. CITIZEN OF WHAT COUNTRY? <u>USA</u>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <u>Howard</u> MD.	
10. CITY OR TOWN OF DEATH <u>COLUMBIA</u>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <u>HOWARD COUNTY GENERAL Hospital</u>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <u>stockman</u>		12b. KIND OF BUSINESS OR INDUSTRY <u>mfg</u>	
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE <u>MD</u> 13b. COUNTY <u>BALT COUNTY</u> 13c. CITY OR TOWN <u>BALTIMORE</u>				13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
14. FATHER'S NAME FIRST <u>Delbert</u> MIDDLE <u>Willey</u> LAST <u></u>				15. MOTHER'S MAIDEN NAME FIRST <u>Florence</u> MIDDLE <u>Hinkens</u> LAST <u></u>			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <u>yes UNK</u> (IF YES, GIVE WAR OR DATES) <u>WW2</u>				16b. SOCIAL SECURITY NO. <u>216 203112</u>			
17. INFORMANT ADDRESS <u>Mr. Clarence Willey 316 4th Ave 21227</u>							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART I. DEATH WAS CAUSED BY:							
1829 IMMEDIATE CAUSE (a) <u>Respiratory Failure</u>							
DUE TO, OR AS A CONSEQUENCE OF (b) <u>Undifferentiated Carcinoma of the Lung</u>							<u>5 months</u>
DUE TO, OR AS A CONSEQUENCE OF (c) <u></u>							
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <u></u>							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR <u></u> A.M. MONTH <u></u> DAY <u></u> YEAR <u>19</u> P.M.		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET <u></u> CITY OR TOWN <u></u> COUNTY <u></u> STATE <u></u>			
22a. I certify that (1) this hospital attended the deceased from <u>9/25</u> 19 <u>83</u> to <u>9/27</u> 19 <u>83</u> , that (1) <u>we</u> last saw the deceased alive on <u>9/27</u> 19 <u>83</u> , and that in my (our) opinion death occurred on the date and hour and from the causes stated above. (If we did not view the body after death, so state.)							
22b. SIGNATURE <u>Francis T Ferraro MD</u>		DEGREE <u>MD</u>		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> HOUSE STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED <u>9/27/83</u>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <u>FRANCIS T FERRARO, MD</u>		22e. ADDRESS <u>Univ of Md Hospital</u>					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>burial</u>		23b. DATE <u>9/30/83</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Lakeview Cemetery</u>		23d. LOCATION CITY OR TOWN <u>Sykesville</u> COUNTY <u>Carroll</u> STATE <u>Md.</u>	
24. FUNERAL DIRECTOR NAME <u>Ambrose Funeral Home</u> ADDRESS <u>1328 Sulphur Spring Rd.</u>				25a. DATE REC'D. BY REGISTRAR <u>SEP 29 1983</u>		25b. REGISTRAR'S SIGNATURE <u>John J. Conner</u>	

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

24701

1. FOR
STATE
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST <i>Pauline I. Woodward</i>			2a. DATE OF DEATH MONTH DAY YEAR <i>September 28, 1983</i>		2b. HOUR P M <i>9:50 P</i>		
3. SEX <i>Female</i>		4. RACE <i>Caucasian</i>		5. DATE OF BIRTH MONTH DAY YEAR <i>Feb. 22, 1898</i>		6. AGE (IN YEARS LAST BIRTHDAY) YEARS MONTHS DAYS <i>85</i>	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <i>Virginia</i>		7b. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <i>Howard</i> MD.	
10. CITY OR TOWN OF DEATH <i>Columbia</i>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <i>Lorien Nursing Home</i>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <i>Housewife</i>		12b. KIND OF BUSINESS OR INDUSTRY	
13a. STATE <i>Maryland</i>		13b. COUNTY <i>Montgomery</i>		13c. CITY OR TOWN <i>Wheaton</i>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST <i>HENRY Ivey</i>		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <i>Minnie Mae Keys</i>		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <i>No</i>		16b. SOCIAL SECURITY NO. <i>579-03-9035</i>	
17. INFORMANT ADDRESS <i>Philip Woodward</i>		18. Son Same as 13		19. Street Address <i>3605 Carey Street</i>		20. ZIP Code <i>20902</i>	

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:

4275

IMMEDIATE CAUSE (a)

Cardiac pulmonary arrest

DUE TO, OR AS A CONSEQUENCE OF

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

(b)

unknown

DUE TO, OR AS A CONSEQUENCE OF

(c)

underlying Cardiac, pulmonary disease

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a)

19a. DATE OF OPERATION —		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED —		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) —			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) —		21f. LOCATION STREET CITY OR TOWN COUNTY STATE —			
22a. I certify that (1) (this hospital) attended the deceased from <i>9/28/83</i> , 19 <i>83</i> , to <i>9/28</i> , 19 <i>83</i> , that (1) (we) lost saw the deceased on <i>9/28/83</i> , 19 <i>83</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (1) (we) (did) (did not) view the body after death. <input checked="" type="checkbox"/>							
22b. SIGNATURE <i>J. E. SEALS</i>		DEGREE <i>MD</i>		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED <i>9/29/83</i>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <i>J. E. SEALS</i>		22e. ADDRESS <i>Columbia MD</i>					

MEDICAL CERTIFICATION

23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <i>Burial</i>		23b. DATE <i>Oct. 1, 1983</i>		23c. NAME OF CEMETERY OR CREMATORY <i>Catlett Cemetery</i>		23d. LOCATION CITY OR TOWN COUNTY STATE <i>Catlett Fauquier Virginia</i>	
24. FUNERAL DIRECTOR NAME <i>Francis J. Collins</i>				25a. DATE REC'D. BY REGISTRAR <i>OCT 6 1983</i>		25b. REGISTRAR'S SIGNATURE <i>Joan J. Connel</i>	
500 University Blvd., W. Silver Spring, Md.							

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Post mortem examination is required by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

